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ABSTRACT

Literature relevant to the needs assessment of children 5 to 12 years of age is reviewed and variables demonstrated to be factors in healthy or deviant behavior are identified. Problems addressed in the review of literature range from school maladjustment through social deviancy to schizophrenia. Five categories of studies are considered: (1) studies of children from minority cultures, (2) studies of lower class children, (3) studies of delinquent behavior (with special emphasis on Maricopa County and the Phoenix South Catchment Area), (4) studies of children of the majority culture, and (5) general interest studies. Most of the information provided concerns the first two categories of studies. The concluding section of the document relates the reviewed material to the issues of community-wide needs assessment, preventive intervention, and therapy. (Author/RH)

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PHOENIX SOUTH COMMUNITY MENTAL HEALTH CENTER

A Review of Literature Pertinent to A Needs Assessment of Children Five to Twelve Years Old

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December, 1975

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INTRODUCTION

This review of literature preceded the development of a field survey instrument intended to uncover community variables conducive to or antagonistic toward children's mental health. Because the target population was identified as five to twelve year olds, the bulk of the literature review concentrated on identifying behavior or situations which appear significant in the development of behavior disorders in children. Longitudinal research studies which were not restricted to middle-class, majority culture people especially caught the reviewer's eye.

The American Psychiatric Association, in coordination with the World Health Organization, recognizes certain behavior disorders of childhood: hyperkinetic reaction, withdrawing reaction, overanxious reaction, runaway reaction, unsocialized aggressive reaction, group delinquent reaction, as well as a miscellaneous "other reaction."[1] The fact that certain behavior disorders are restricted to childhood and adolescence does not mean these are the only disorders to which children fall prey. This essay does not appear the place to present a discussion of each of these disorders. Meeks (1975) and especially Coleman (1972) provide good presentations.

[1] The source for these classifications is the Diagnostic and Statistical Manual of Mental Disorders, 2nd Edition, often referred to as DSM-II.

John Meeks (1975) states that faulty parental attitudes or child-rearing practices are the heart of all childhood behavior disorders other than hyperkinesis.[2] He admits that certain constitutional temperamental factors "may play significant roles in the development of some behavior disorders" (Meeks, 1975, p. 2127), but maintains that the majority of difficulties stem from "relatively specific patterns of family malfunction which are chronic and extend over much of the child's early development." (P. 2127). Two implications appear readily inferrable from Meeks' remarks. One, family therapy is a necessary intervention in childhood behavior disorders; two, an understanding of profiles or systems of urban poverty families would be helpful for family therapists. Family therapy is discussed later in this essay. Another aspect, however, must also be considered, namely, the significance of social systems larger than the family in the development of children's behavior. A main social system of this larger category is the school and this review includes studies of children in school.

[2] However, according to Coleman (1972) the label "hyperactive reaction" tells little as regards etiology or appropriate treatment procedures for the behavior disorder. Evidence concerning irregular or altered brain processes as cause of hyperkinesis is not adequate. In fact, the appearance of hyperactivity in later childhood likely stems from family and related stress, according to Coleman.

MINORITY CULTURE CHILD STUDIES

Abstract

Material in this section reviews literature whose data provide research information concerning children of minority cultures. One author (Connors, 1970) has researched variables which significantly differentiate patients in child guidance clinics from children considered relatively untroubled. He identifies variables which are significantly present among lower socioeconomic level children.

Researchers (Kellam and Schiff, 1967; Schiff and Kellam, 1967; Kellam et al, 1975) in a Black urban area of Chicago worked with teachers to identify functional and maladaptive children. They identified five tasks considered adaptational and discovered that teacher ratings were closely related to independent clinical assessments made of the children. The researchers make favorable judgments regarding the predictive value of their approach, provide information regarding sex differences, and compare their work with that of the first author mentioned.

Two authors (Herzog and Sudia, 1973) review literature concerning the effects of fatherless homes upon children. They caution against blanket generalizations about the deleterious effects of such homes upon children.

Family profiles of urban slum families are reviewed by five family therapists (Minuchin, et al, 1967). The researchers present descriptions of five distinct family types: "disengaged" families, "enmeshed" families, families with a "peripheral male," families with "non-evolved parents," and families with "juvenile parents."

Three social scientists (Padilla, Ruiz, and Alvarez, 1975) present strong opinions about the inadequacy of mental health services for the poor. They focus on the Spanish-speaking surnamed poor whose culture is strikingly different from that of most therapists.

Two investigators (Stoker and Meadow, 1974) study case records of Mexican-American and Anglo-American children from three child guidance clinics in Southwestern cities. They present a checklist of symptomatic behavior, indicate that certain symptoms are culture-specific, and indicate that certain symptoms are sex-linked for Mexican-American children. Their findings show that diagnoses of these children remain similar regardless of the children's ethnicity. However, certain behaviors are shown to be problematical for Mexican-American children.

Two researchers (Hosford and Bowles,1974) attempted to demonstrate whether certain items or activities would enable Anglo-American and Mexican-American children to improve reading skills. Nine of the reinforcers were chosen often by the children; sex differences rather than ethnic differences were linked more often to frequent choices. The children in the experimental groups attended class more frequently than they had previously, and they improved their reading skills. The researchers indicate such an approach has implications for improving the school life of Chicano students overall.

Certain childhood symptom patterns have attracted the attention of researchers. In one study, the researcher (Conners, 1970) adapted from an article in American Journal of Orthopsychiatry (1960,330, pp.113-29) a checklist of symptoms which interviewers could use to ask parents about their children. He factor analyzed the ratings which parents in East Baltimore gave their children's behavior; 316 children were patients of a psychiatric clinic and 365 children were considered normal and used as a control group. The children ranged in age from five to fifteen. Sex, socioeconomic, and racial variables are noted in the study. The sex and racial characteristics of the inpatients were: 227 White males, 46 White females, 31 Black males, and 12 Black females. Sex and racial characteristics of the control group were: 86 White males, 59 White females, 106 Black males, and 89 Black females. The controls were selected from four different schools, two of which were all Black and two of which were all White. One Black and one White school were considered middle socioeconomic, and one Black and one White school were considered lower socioeconomic.

After obtaining symptom ratings from parents about their children, the investigators matched 223 patients and 221 controls according to sex, race, socioeconomic level and symptom ratings. Several variables significantly differentiated ($p < .001$) patients from controls. Although both groups showed

the same basic factor structure, patients exhibited greater prevalence and severity of the following symptoms than did the controls: sleep problems, muscular tensions, fears and worries, wetting, complaints of symptoms, overassertion, problems making friends, problems with siblings, problems keeping friends, restlessness, temper, lying, stealing, fire-setting, school problems, and sex problems.[3] (Conners, 1970).

Conners (1970) considered socioeconomic class effects to be slight. He did report, however, that lower socioeconomic level children scored significant differences ($p < .05$) from middle socioeconomic level children in problems with siblings, psychosomatic complaints, lying, overassertion, problems making friends, and muscular tension.

As for racial differences, significant differences were linked directly with socioeconomic level. Black mothers of children from the lower socioeconomic families reported a significantly greater ($p < .05$) number of wetting symptoms, problems in school, lying, stealing, sex, psychosomatic complaints, troubles with feelings, and immaturity. These mothers reported their children to have speech problems with striking significance. ($p < .0001$).

[3] Conners does not identify whether school problems have to do with achievement or something else. Sex problems involve sex play with others and masturbation.

A large-scale program to assess needs in first-grade classrooms of Woodlawn, an urban community of 82,000 Black people in south Chicago, provides some data of importance. The Woodlawn assessment originated in a local mental health clinic supported by several community organizations. The purpose of the investigators was twofold: assessment of mental health needs of first-graders and prevention and early treatment of maladaptive youngsters (Kellam and Schiff, 1967).[4]

The rationale of the investigators was that the first-grade child is thrust into a situation in which an adult makes rules and has expectations regarding behavior. Regardless of variations from teacher to teacher, the child has to conform to one classroom setting. Fifty-seven first-grade teachers were asked to rate their own pupils according to presence of maladaptive behavior. A four-point rating scale, which transformed five adaptational tasks into categories ranging from adapting to severely maladapting, was applied to each child after the interview with the teacher. These five adaptational tasks were social contact, acceptance of authority, maturation, cognitive achievement, and concentration.[5] A sixth task, global adaptation was added to obtain an overall view of the child's status. The investigators obtained ratings three times from the first-grade teachers and, in a follow-up study, once from the third-grade teachers (Kellam and Schiff, 1967).

[4] The authors provide no information about sex differences in their preliminary reports of the Woodlawn projects. A book published in 1975 does provide information, and this reviewer will present that information.

[5] Behavior associated respectively with these five categories: friendless, steals, cries too much, lack of effort, and restless. Prior to development of the scale, each of the teachers had given to the investigators a list of ways children have problems adapting to school.

First-grade classrooms were matched and then assigned as recipients of the intervention program or as control groups. Over 2,000 Black children in all were either part of the experimental or control group.[6] The intervention program, called brief by the authors, involved training school staff members to be the interveners for children with identified problems. This training involved weekly one-hour meetings with staff members and weekly half-hour meetings with the first-grade teacher and pupils identified by her as maladaptive. School staff meetings, which focused on issues relevant to a first-grade child's capacity to continue school, involved discussions of such issues as school-community relations, individual children's problems, intra-staff difficulties, and the hopelessness felt by the families. Classroom meetings, which appear to have been similar to meetings described by Glasser (1969) in Schools Without Failure, were conversations between the children, the teacher, and the psychiatrist about the significance of first-grade to each individual and the importance of success in first-grade tasks (Schiff and Kellam, 1967).

Clinical assessments of each child were made independent of knowledge of teacher ratings for that child. Teacher ratings and clinical assessments of mental illness were closely related. Children assessed mentally ill early in the first grade had been consistently judged maladaptive on the social contact, maturation, and global adaptation scales (Kellam and Schiff, 1967).

[6] One of the first measured impacts of the intervention program was increased teacher expectations. Numerous experimental studies of teacher-student interaction have shown the power of teacher expectation upon student performance.

Furthermore, the investigators concluded that at the beginning of first grade maladaptive but non-symptomatic children run "a much higher risk than the adapting children of becoming symptomatic by the end of first grade" (Schiff and Kellam, 1967, p. 94). The authors estimated the probability as nine to one that the socially maladaptive youngster would develop psychiatric symptoms before the end of the school year (Kellam and Schiff, 1967).

Since the publication of the Sheppard/Kellam articles, Kellam and three of his colleagues have written a book about the Woodlawn project. The book provides information about sex differences and compares the Woodlawn findings with those of Conners (1970) in his study of mothers' ratings of their children's symptoms. This reviewer discusses the Woodlawn findings about sex differences before he compares the findings of the two studies.

Except for social contact, first grade girls in Woodlawn were rated as better adapted than boys at the beginning of school. No significant difference was evident in the social contact behavior (Kellam, Branch, Agrawal, and Ensminger, 1975). Of 824 girls and 887 boys, 104 girls were rated at the start of school to accept authority better than did boys; 59 girls were rated more mature than boys; 63 girls were rated higher in cognitive achievement than were boys; 98 girls were rated able to concentrate better than boys; 76 girls were rated overall to be better adjusted than were boys; (Kellam, Branch, Agrawal, and Ensminger, 1975).

At the end of the first grade, the teachers continued to rate the girls as better adapted than the boys except for social contact on which there remained no significant difference. On all ratings except for the global rating the number of girls considered better adapted than boys increased.

One hundred-thirty-four girls were now considered to accept authority better than did boys; 115 girls were rated more mature than boys; 71 girls were considered to be higher than boys in cognitive achievement; 148 girls were rated better able to concentrate than boys; however, now 71 girls rather than 76 were rated better adapted to school overall (Kellam, Branch, Agrawal, and Ensminger, 1975).

The authors remark that other studies have noted a disparity when girls and boys are rated according to maladaptation. Boys continually seem to show greater frequency of maladaptive symptoms. The authors remark that not only teacher ratings but also peer ratings bear out this disparity. In the opinion of these authors, these findings may indicate more that boys' maladaptive behaviors are observable, not internalized, rather than that girls do not experience difficulties. Another hypothesis offered is that sex role identity helps girls to exhibit school behavior considered adaptive by teachers. The researchers acknowledge that earlier maturation may be the significant factor governing better school adaptation on the part of girls (Kellam, Branch, Agrawal, and Ensminger, 1975).

The Woodlawn investigators personally interviewed the mother or mother-surrogates responsible for the care of the first-grade children. They do not report that any male adults acted as mother-surrogates. The persons who interviewed these women were also Black and female (Kellam, et al, 1975).

The mothers were asked about symptoms of their children. When Conners supplied Kellam and his colleagues with his data, they compared findings after matching subjects for age (children six to eight years old). The Woodlawn investigators stated that Conners' small number of Black children

in clinic treatment prohibited any comparison between them and the Woodlawn children. They found Conners' control population and White clinic population sufficiently large to warrant a comparison.

The following tables, which have been adapted from the Woodlawn reseachers, present a comparison of Conners' population and the Woodlawn children. The figures given relate to the percentage of children in each sample. The first table indicates significant differences between the Woodlawn children and all or some of the White children on nine of thirty-one symptoms.

[INSERT TABLE I HERE]

TABLE I

A Comparison of Woodlawn Children with White Children in East Baltimore

MSI Items Grouped by Categories of Symptoms	Woodlawn Children N=863	Clinic White Lower N=38	Clinic White Middle N=73	Control White Lower N=45
Fears				
Afraid of new situations	28.4	63.2**	67.1**	40.0
Afraid of people	9.1	28.9**	32.9**	22.2**
Afraid of being alone	37.7	64.9**	57.5**	42.2
Afraid to go to school	6.1	25.0**	20.5**	13.3
Muscular tension				
Muscles get stiff and rigid	8.0	39.5**	21.9**	15.6
Twitches and jerks, etc.	15.1	39.5**	31.5**	22.2
Sleep problems				
Restless (or awakens at night)	20.4	65.8**	54.2**	48.9**
Has nightmares	18.7	31.6(*)	36.1**	33.3*
Speech problems				
Doesn't speak clearly other than stuttering	27.4	45.9*	30.1	11.1*

Note: For each symptom item the ratings of Woodlawn children and East Baltimore children were divided into "not at all" (0) and "a little bit," "pretty much," and "a lot" (1+2+3). Chi square tests were applied to compare the relative frequency of a given symptom in the Woodlawn population and the frequency of that symptom in the various groups in Conners's population.

**Indicates significant at the 0.01 level of probability.
*Indicates significant at the 0.05 level of probability.
(*)Indicates significant at the 0.10 level of probability.

Adapted from Kellam, Branch, Agrawal, and Ensminger, 1975.

Table I indicates the Black ghetto children in Woodlawn are significantly unlike the White children in East Baltimore clinics. Fears, muscular tensions, and sleep problems were seen as areas of pronounced difficulty by the East Baltimore mothers whose children were clinic patients.

This reviewer wishes to raise at least one question regarding the data by Kellam and his colleagues. We are told that the 863 Woodlawn children differ significantly in several behavioral areas from thirty-eight White lower socioeconomic and seventy-eight White middle socio-economic children who are clinic patients. Presumably none of the extremely large number of Woodlawn children are being seen in child guidance clinics. However, what if even 10% (eighty-six) of these Woodlawn children are being seen in clinics? If the mothers' reports on these eighty-six children were compared to those on the East Baltimore clinic patients, would the results be significantly different? It appears likely that 780 normal children would absorb and erase the influence of eighty-six child guidance patients' symptoms.

On one symptom of speech problems, White lower socioeconomic children in the control group and in the clinic group scored significantly different, but in opposite directions respectively, from the Woodlawn children. This symptom is "not speaking clearly other than stuttering." The authors note that 95 times out of a hundred the symptom would seem to identify White lower socioeconomic children who need clinical help.

As the following table indicates, the Woodlawn children more resemble Conners' control groups (White and Black children) than they resemble the children in clinics. However, in six behavioral areas at least one of the control groups of the East Baltimore children differs significantly ($p < .01$)

from the Woodlawn children.

[INSERT TABLE II HERE]

Table II indicates no predominant behavioral area in which the Woodlawn children differ from the children in Conners' control groups. As indicated in Table I three areas (fears, muscular tensions, and sleep problems) significantly differentiated the Woodlawn children from White children in clinics. The control groups differ on six symptoms, but, as Table II shows, not every control group significantly differs from the Woodlawn children on all six symptoms.

The Woodlawn investigators singled out for special attention the stuttering problems of the Black lower socioeconomic children in East Baltimore. Even though the mothers of Woodlawn children did not report stuttering nearly as frequently as did their counterparts in Connors' study, Kellam and his colleagues believe it would be valuable to investigate "why this particular population (in East Baltimore) exhibited such a high frequency of stuttering and why this symptom was not particularly prevalent in the clinic children." (Kellam, et al, 1975, p. 90).

It is informative that mothers in Woodlawn and in East Baltimore reported their children had trouble with feelings and had eating problems. However, the reports did not differ to any significant degree. An examination of Table III will show that in two cases ("lets himself get pushed around" and picky and finicky about food"), no less than 42% of the mothers reported their children had problems. In some cases, 71% of the mothers report

TABLE II

A Comparison of Woodlawn Children with Controls

(White and Black) in East Baltimore

MSI Items Grouped by Categories of Symptoms	Woodlawn Children N=863	Control White Lower N=45	Control Black Lower N=38	Control Black Middle N=45
Fears				
Afraid of people	9.1	22.2**	2.6	16.7
Nervous habits				
Bites or picks nails	22.9	37.8*	47.4**	16.7
Sleep problems				
Restless (or awakens at night)	20.4	48.9**	18.4	14.6
Complaints of symptoms when doctor finds nothing wrong				
Headaches	29.2	22.2	26.3	10.4**
Stomachaches	41.3	28.9	44.7	18.7**
Speech problems				
Stutters	14.5	13.3	36.8**	8.3

**Indicates significance at the 0.01 level of probability.
*Indicates significance at the 0.05 level of probability.

Adapted from Kellam, Branch, Agrawal, and Ensminger, 1975.

symptoms; these mothers differ racially and socioeconomically.

[INSERT TABLE III HERE]

Overall results indicate that the Woodlawn children more resemble Conners' control groups than they resemble the children in clinics. In twenty out of thirty-one symptoms, clinic children's frequency of symptoms was significantly higher than that of the Woodlawn children. The Woodlawn investigators claim that racial, socioeconomic, and community differences between the two geographical areas of Woodlawn and East Baltimore seemed to influence the presence of symptoms in variant patterns. These variant patterns were not clearly described by the author (Kellam, et al, 1975).

To employ the list of symptoms in any needs assessment survey, it would appear prudent to identify overall patterns which indicate possible adjustment difficulties of children. For example, any report that a child fears people would be probed for the frequency, duration, and severity of this fear. Investigators might find that the child fears a neighbor who hurt him or is cautious with strangers. It would be prudent to note the circumstances in which this symptom is exhibited before deciding whether or not the symptom indicates pathology.

TABLE III

A Comparison of Woodlawn Children with East Baltimore Children, no Significant Differences

MSI Items Grouped By Categories of Symptoms	Woodlawn Children N=863	Clinic White Lower N=38	Clinic White Middle N=73	Control White Lower N=45	Control Black Lower N=33	Control Black Middle N=48
Trouble with feelings						
Keeps anger to himself	27.3	26.3	17.8	22.2	31.6	27.1
Lets himself get pushed around by other children	50.9	42.1	42.5	57.8	52.6	47.9
Eating problems						
Picky and finicky about food	62.5	65.8	65.8	71.1	65.8	70.8
Overweight	7.6	10.5	4.2	4.4	5.3	14.6

Adapted from Kellam, Branch, Agrawal, and Ensminger, 1975.

Recently the Children's Preventive Services of Phoenix South Community Mental Health Center studied four housing projects. The results indicate that a considerable number of children are growing up in fatherless homes. Because several sources as variant as folk-wisdom, research studies, and popular views on law and order trace many social problems to fatherless homes, a review of research into the effects of fatherless homes appears relevant for our catchment services.

It is instructive to read an extensive study of children in fatherless homes done by Herzog and Sudia (1973). These authors maintain that despite notable exceptions every research study into mental illness and fatherless children lacks comparison with a control group. "Taken as a whole, the evidence, with regard to mental illness and broken homes, is ambiguous and conflicting. Research evidence does not establish or rule out an association between father's absence and mental illness" (Herzog and Sudia, 1973, p. 185). Thus, these authors reject blanket generalizations about the deleterious effects on children who lack a father.

Such research conclusions seriously undermine the popular opinions, especially prevalent in current "explanations" of increasing crime rates, of a link between fatherless homes and mental illness. In fact, in some cases, absence of fathers from the home [7] may be beneficial to children when their fathers have psychiatric symptomatology. For example, Robins' (1966) study of sociopathic personality development firmly supports the view that the presence in the home of antisocial fathers is deleterious to children.

[7] Absence in this case means seldom, if ever, present rather than occasionally gone from the house.

Herzog and Sudia argue that complicated interaction variables condition and on the the whole mediate the impact of a father's absence on a child. Elements which influenced a child regardless of her father's presence continue to affect the child after he leaves. The authors believe that family members' functioning "is likely to be more crucial to a child's development than is the number of parents in the home" (Herzog and Sudia, 1973, p. 214). The authors would include general family climate and the mother's coping ability and role as part of family functioning. In addition to family stress and conflict, inadequate supervision of children, and the mother's reactions to separation from her husband, Herzog and Sudia mention depressed income, living conditions, neighborhood influences, and community attitudes toward the child and his family as important factors in production of juvenile delinquency.

Minuchin's profiles of urban slum families contain material to consider at this point. The majority of these families are members of ethnic minorities. Minuchin has investigated the functioning of these families in depth, and almost all of the families he discusses in Families of the Slums (Minuchin, Montalvo, Guerney, Rosman, and Schumer, 1967) are fatherless. The authors say that fathers who are present in any of the homes accept an impotent role or are forced to leave.

Minuchin worked with a residential home for emotionally disturbed boys from urban ghetto areas of New York City. He directed the family therapy efforts offered by the home. From his family work, he delineated five profiles of disorganized, disadvantaged families: the "disengaged" family, the "enmeshed" family, the family with a "peripheral" male, the family with a "non-evolved"

parent[8], and the family with "juvenile parents" (Minuchin, Montalvo, Guerney, Rosman, and Schumer, 1967). Descriptions of these family profiles are given below in words that paraphrase Minuchin and his colleagues.

According to Minuchin and his colleagues, the "disengaged" family is characteristically disconnected, and the family members' relationships severely test the systems theory focus of family therapy. "They act as parts of a system so loosely interlocked that it challenges the clinician's notions that a change in one part of the system will be followed by a complementary change in other parts" (Minuchin et al, 1967, p. 354). The authors describe the mother of a disengaged family as noticeably incapable of controlling the family, contacting the external world, or drawing on external resources. Male figures are never stable, and usually are played by a series of peripheral males. Disengaged families lack autonomy, organization, and self-initiation. Minuchin[9] calls these families poor candidates for community programs; however, once therapy has increased the mother's competence in her home, the authors maintain that auxiliary services such as a homemaker or the YMCA become indispensable for maintaining gains (Minuchin et al, 1967).

Families of the Slums says that "enmeshed" families correspond with traditional systems theory explanations of family functioning: any attempts to change on the part of one member in an enmeshed family elicit quick, complementary resistance on the part of others. Enmeshed family members use each other as

[8] The term "non-evolved" is correct. Several proofreaders of the original draft questioned whether the correct term is "non-involved."

[9] Unless specifically noted otherwise, singular references to Minuchin include his colleagues as well.

triggers for instant reactions. All interactions are variations of struggles for power; the mother perceives control her most important asset in this family and equates helplessness with a loss of control over the other family members. Unlike disengaged families, which do not cope well with the external world, enmeshed families skillfully deal with external sources. The power maneuvers between family members are transferred to the family's external dealings. Authoritarian agencies such as the courts or police are seen as tough opponents, whereas nurturing agencies such as health clinics are seen as exploitable victims (Minuchin et al, 1967).

Minuchin places families with a "peripheral male" in the middle range of a disengaged-enmeshed continuum. He describes the role which a man plays as a function of the female adult's role: if she adopts a disengaged position, the male adult participates more readily in family functioning; if she adopts an enmeshed position, her needs for control coupled with a strong need to function as a mother, relegate the male adult to the outskirts of family functioning. When excluded from the family, these peripheral males participate actively in external peer groups rather than attempt to undo their exclusion "by intrusive and ineffective attempts" to be part of the family. The authors say that mother and children ally against a peripheral male, upon whom they project the responsibility for the family's unhappiness. As would be expected, the mother's executive functions include dealings with social agencies, in particular those affecting her children (Minuchin et al, 1967).

Families with a "non-evolved parent" are controlled by a maternal grandmother, who treats her daughter and her grandchildren as members of a sibling subsystem. Thus the mother of these children is interacted with as though she were her children's sister, and the grandmother acts as the mother for all. The family

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interactions prevent the young mother from entering into any adult male/female relationships. Minuchin says that one would appropriately term this young woman an "arrested" personality (Minuchin et al, 1967).

In another publication Minuchin (1967) calls attention to the fact that the family with a non-evolved parent does not function as a three generation family; he identifies it as pseudo-extended regardless of its outward appearance.

> *A new child is born to a family, but there are almost no changes which occur beyond the introducing of the biological labels "mother" and "grandmother;" there are no changes in the functional organization of the family. The daughter is unable to become a mother because of the rigidity of her daughter role. Similarly, the grandmother role fails to emerge; the older woman remains the central mother, with the daughter's infant becoming an additional child instead of a grandchild. These failures in moving toward the development of a three generation extended family, away from a two generation pseudo-extended family, are typical in our population (Minuchin, 1967, p. 148).*

According to Minuchin, families with "juvenile parents" are characterized by parents who primarily relate to peer reference groups rather than to each other as adults. He says that the mother will see herself as a "fickle girl" and is often promiscuous. She is the family's executive. Because she ineffectually nurtures her children, Minuchin says the father becomes the children's nurturer. However, the mother feels burdened by incompetent people in her life, and she clusters her husband and children into a subsystem not unlike the sibling subsystem into which maternal-grandmothers cluster their daughters. Minuchin states that parental strife in such a family may often pass from one crisis to the next without threats of impending separation ever being acted upon. Children in families with juvenile parents develop divided loyalties as they find themselves adopting the role of mediators of parental conflict. The authors state that these children typically become confused about sex roles (Minuchin et al, 1967).

Family therapy by definition is a program for intervention in a difficulty. Minuchin and his colleagues point out that more than family therapy is required to intervene in behavior difficulties associated with other social systems. These authors, however, are not optimistic about the effect of large-scale intervention programs to alter "the larger sources of social pathology which perpetuate and foster the disorganization of groups and individuals" (Minuchin et al, 1967, p. 370). They are equally clear that reliance on psychotherapy to alter these larger sources of social pathology is misplaced. Minuchin and his co-authors call for intensive study not only of the mechanisms whereby "the culture of poverty" is transmitted but also the mechanisms whereby resistance to or modification of that culture is transmitted (Minuchin et al, 1967).

A recent article in The American Psychologist (Padilla, Ruiz, and Alvarez, 1975) addresses the issue of appropriate community mental health services for persons identified by the U. S. Bureau of the Census as of Spanish origin. Padilla and his colleagues identify this population as "Spanish-speaking/surnamed" (Padilla et al, 1975).

The authors assert that traditional health care delivery models misrepresent the problems, mainly social in nature, affecting the Spanish-speaking/surnamed (SSS) population. "Intrapsychic conflict," they claim, "represents only a small portion of the numerous human and social problems that trouble the SSS" (Padilla et al, 1975, p. 904). They cite some representative problems: "premature termination of education among the young, elevated rates of arrest and incarceration, widespread abuse of alcohol and illegal drugs, and high rates of unemployment" (Padilla et al, 1975, p. 900).

According to Padilla and his colleagues certain factors, which are part of the social nature of problems which affect the SSS, point to why this minority culture receives poorer mental health care than other citizens in this country. They assert that poor English language skills, limited education, low income, depressed social status, little political power, and few effective and marketable skills in this technological society severely hamper use of mental health care by the SSS. These authors maintain that these factors point to a high incidence of disintegrated personalities in need of psychological help. However, Padilla, Ruiz, and Alvarez maintain that demographic data not only indicate that the SSS receive inadequate mental health care but that demographic data also "under estimate the frequency and severity of mental health problems" experienced by the SSS (Padilla et al, 1975, p. 893).

A lengthy study of cultural differences in child guidance clinic patients offer relevant material for inclusion in this review. For example, a large sample of Mexican-American and Anglo-American children were matched and compared; the case records were randomly drawn from three clinics in large southwestern cities; one of these clinics was Jane Wayland Child Guidance Center, with which Phoenix South Community Mental Center has a working relationship (Stoker and Meadow, 1974).

Stoker and Meadow decided to study child guidance patients from Anglo-American and Mexican-American culture groups. They wanted to determine whether patterns exist which aid in understanding "the wide and consistent differences in the psychopathology of adult Mexican-American and Anglo-American clinical groups" (Stoker and Meadow, 1974, p. 186).

Numerous data emerged from the sample of 152 Mexican-American and 152 Anglo-American cases chosen for study. All of these cases were part of a random selection of cases seen by the clinics within the past two years. The investigators state that they eliminated any cases of organic pathology or mental deficiency and retained only cases of functional psychopathology (Stoker and Meadow, 1974).

The 152 Mexican-American and 152 Anglo-American children were matched for sex and included 76 males and 76 females in each cultural group. The cases were matched for socioeconomic level. The socioeconomic matching was accomplished by using the total gross family income of patients' families. The socioeconomic breakdown was: $0-2,999 - 43% of each sex in the cultural groups; $3,000-5,999 - 51% of each sex in the cultural groups; $6,000 plus - 6% of each sex in the cultural groups. The children were matched for age. The children ranged in age from four to eighteen. Nine per cent of the 304 children were between the ages of four and six, 77% were between seven and fifteen, and 14% were between sixteen and eighteen (Stoker and Meadow, 1974).

The investigators made a preliminary study of a number of case records from which they constructed a checklist of seventy-four symptomatic behaviors. The authors report that inter-rater reliability was estimated by independent assessment of ten cases; the investigators agreed over 98% of the time in their assessment of symptoms. "In no case was there more than one disagreement per symptom category across all subjects, indicating no systematic rater bias" (Stoker and Meadow, 1974, p. 193).

The checklist of seventy-four symptoms can be sorted according to frequency with which each culture group and each sex within a culture group manifested certain symptoms. Variation in occurrence of symptoms between culture groups or sexes enables some differentiation to be noted. Symptoms which occurred with a higher frequency for Mexican-American than Anglo-

American children included agitation, aggressive behavior, crying spells, dependency, depressions, fights, hyperactivity, impulsivity, running away from home, stealing, and somatic complaints. Anglo-American children exhibited a higher frequency of academic problems, anxiety, nailbiting, enuresis, nervousness, nightmares, no or few friends, poor social relationships, and temper tantrums (Stoker and Meadow, 1974).

At least 20% of the Mexican-American male children exhibited the following symptoms: academic problems, aggressive behavior, dependency, fights, hyperactivity, hostility, impulsivity, negativism, obstinancy, passivity, stealing, and temper tantrums. Hostility and stealing were the symptoms most noted. Forty-five per cent of the male Mexican-American children exhibited hostility, and 36% exhibited stealing; none of the other high frequency symptoms were noted in more than 26% of the cases (Stoker and Meadow, 1974).

Mexican-American female children had six symptoms of high frequency: crying spells, depression, hostility, immaturity, running away from home, and somatic complaints. Depression (39%) and somatic complaints (36%) occurred with the greatest frequency. Hostility was noted in 30% of the cases. Crying spells (28%), running away from home (24%), and immaturity (21%) occurred with less frequency than the three other high frequency symptoms (Stoker and Meadow, 1974).

Anglo-American boys and girls exhibited the following symptoms in high frequency:[10] academic problems (36% - 22%), anxiety (42% - 54%), biting nails (18% - 25%), enuresis (37% - 28%), hostility (16% - 20%), nervousness (30% - 25%), no or few friends (36% - 29%), and poor social relationships (33% - 20%).

[10] Percentages noted first for the 76 boys, then for the 76 girls.

At least 20% of Anglo-American girls exhibited nightmares and temper tantrums whereas few Anglo-American boys exhibited these symptoms (Stoker and Meadow, 1974).

The top five symptoms for each ethnic group and the level of frequency for each symptom can be placed in parallel columns. The Mexican-American sex-typed differences and the Anglo-American similarities become visually apparent when the list of high frequency symptoms are so organized.

[INSERT TABLE IV HERE]

It is interesting to note that Anglo-American boys and girls almost invariably exhibited the same symptoms of high frequency whereas Mexican-American children exhibited this pattern in only one case, viz. symptoms of hostility. Perhaps such data point to different sex role identification patterns in these two cultures. It would seem that Mexican-American symptomatology is more obviously sex-linked whereas Anglo-American is not. Another datum is worth note: in no cases do the two different cultures exhibit high frequency of occurrence for the same behavior symptom (Stoker and Meadow, 1974).

The investigators noted outcome of cases according to the same categories previously used to group symptoms: sex and cultural group. All the data regarding positive and negative outcome indicated "that there is a high probability for a Mexican-American child not to profit from the general services of a child guidance clinic" (Stoker and Meadow, 1974, p.197). The investigators noted that Mexican-American children who did start in a clinic, dropped out of therapy at a higher rate than did the Anglo-American children.

Padilla and his colleagues relate certain factors which may aid in understanding why the Mexican-American children dropped out of therapy at a higher rate than the Anglo-American children.[11]

[11] The following ideas are suggestions, not conclusions. Because this author does not know how the three clinics in question handled the cases, no conclusions are warranted.

TABLE IV

Rank Order of High-Frequency Symptoms For

Mexican-American and Anglo-American Boys And Girls

Mexican-American				Anglo-American			
Boys (N=76)		Girls (N=76)		Boys (N=76)		Girls (N=76)	
Hostility	45%	Depression	39%	Anxiety	42%	Anxiety	54%
Stealing	36%	Somatic complaints	36%	Enuresis	37%	No or few friends	29%
Fighting	34%	Hostility	30%	No or few friends	36%	Enuresis	28%
Aggressive behavior	26%	Crying spells	28%	Poor social relationships	33%	Bites nails	25%
Hyperactivity	24%	Running away from home	24%	Nervousness	30%	Nervousness	25%
Negativism	24%						
Obstinancy and defiance	24%						

Adapted from Stoker and Meadow, 1974.

Four variables which adversely affect use of mental health services by the Spanish-speaking/surnamed population are: geographic isolation, language barriers, class-bound values, and culture-bound values. The last three variables especially discourage the SSS from utilizing mental health services (Padilla et al, 1975).

Language barriers need no explanation. Transportation costs and ignorance of services would be two factors to make geographic isolation affect use of services. Class- and culture-bound values deserve mention at greater lengths than given for the first two factors.

More than 95% of the children in the Stoker and Meadow study came from lower socioeconomic level families.[12] Padilla and his colleagues refer to numerous studies which have indicated that therapists, who seldom if ever come from lower socioeconomic levels, conduct sessions "in accordance with the value system of the middle class" (Padilla et al, 1975, p. 896). However, Padillla and his colleagues maintain that lower socioeconomic level patients fail to respond to fifty minute individual or group therapy sessions conducted once or twice a week. When such therapeutic approaches prove "ineffective with and discouraging to lower-class patients," therapists "are more likely not to encourage the SSS client to seek therapy after the first meeting" (Padilla et al, 1975, p. 896).[13]

[12] Four Mexican-American and nine Anglo-American children came from families with incomes of $7,000 or more. These thirteen children comprised 4.2% of the children.

[13] A book outlines a systematic approach designed for poverty level persons in need of therapy. See Arnold Goldstein, Structured learning therapy: Toward a psychotherapy for the poor. NY: Academic Press, 1973. Goldstein presents a combination of modeling, role playing, and social reinforcement as a means of doing psychotherapy with the poor. His method actively involves the patient behaviorally.

According to the references mentioned by Padilla and his colleagues, middle-socioceonomic therapists should have found it most difficult to work successfully with any of these lower socioeconomic children. And yet, despite similar lower socioeconomic backgrounds the Anglo-American children stayed in therapy longer than did their Mexican-American counterparts. Such data do not support an appeal solely to socioeconomic differences between therapists and patients to explain differences in patient drop-out rates from therapy. However, other factors do immediately suggest themselves.

Culture-bound factors, discussed below on pp. 29-31 of the essay, present another possible explanation for the discrepancy between Mexican-American and Anglo-American drop-out rates. Padilla and his colleagues draw attention to cultural differences between therapists and clients. They believe "an inherent probability of professional misjudgment" accompanies diagnosis and treatment prescriptions whenever therapists and patients come from different cultures (Padilla et al, 1975, p. 896).

It is clear that the Mexican-American children had been judged to be improved significantly less than their Anglo-American counterparts ($p < .01$). They also had dropped out of therapy at a rate higher than that of the Anglo-American children. Because the children's socioeconomic levels were the same, it seems that a combination of factors such as language barriers and culture-bound value differences, would provide reasonable answers for the discrepancies between the Mexican-American and Anglo-American children in Stoker and Meadow's study (1974). They did conclude from their data that"there is a high probability for a Mexican-American child not to profit from the general services of a child guidance clinic" (Stoker and Meadow, 1974, p. 197).

Diagnoses of the children included several behavior disorders. Both groups exhibited similar patterns of behavior disorders. Anglo-American children exhibited

neurotic disorders at a rate higher than Mexican-American children (11% vs 6%), but the difference is not statistically significant.

A major difference between Mexican-American boys and the other children is evident in one disorder subtype, passive-aggressive personality disturbance; 27% of the Mexican-American boys were given this diagnosis. Other children's behaviors were diagnosed as passive-aggressive personality disturbances significantly less than the 27% figure for the Mexican-American boys; 8% for Mexican-American girls, 14% for Anglo-American boys, and 12% for Anglo-American girls.

Although the two cultural groups were rated practically equivalent for incidence of passive-aggressive personality disturbance, (Mexican-American, 18% to Anglo-American, 13%) such equivalent figures belie the significant differences between the Mexican-American boys and girls. The fact that Anglo-American boys and girls were rated equivalent for this behavior (14% to 12%) whereas Mexican-American boys and girls were rated quite unequivalent (27% to 8%) supports the thesis that certain behaviors are more sex-role stereotyped in Mexican-American cultures.

Indications of sex differences among the Mexican-American children are apparent from the data which present symptom frequency and behavior diagnoses. Stoker and Meadow (1974) studied the symptomatology of the Mexican-American children to learn more about the differences which accompany symptoms.

Mexican-American female children in the clinics consistently exhibited such primary symptoms as attempted suicide (17%), crying spells (28%), depression (39%), and agitation (18%). Stoker and Meadow link such behavior to adult behavior problems typical of Mexican-American females. They refer to a

1965 study in which Mexican-American female adult hospital patients exhibited "an agitated depressive condition in which there is considerable disturbance of affect" (Stoker and Meadow,1974, p. 197).

These authors report that serious depression is a common development among six to eight year old Mexican-American children. Their data concerning the children in clinics indicate a remarkable difference in incidence between depressed Mexican-American children and Anglo-American children: a difference of 2 to 1. According to Stoker and Meadow's data the risk of a Mexican-American girl in the clinic sample becoming depressed as compared to the risk run by a Mexican-American boy or Anglo-American girl in the clinic sample is even more remarkable: 3 to 1 (Stoker and Meadow, 1974).

The depression for adults from these two cultural groups takes on noticably different patterns. Adult Mexican-American clinic patients "experience a depressive mood, agitation, and feelings of anger, differing quite sharply from the Anglo-American patient who typically feels heavy guilt, self-depreciation, and accompanying depression" (Stoker and Meadow,1974, p. 198). Stoker and Meadow maintain that these cultural differences in depression point up the necessity to appreciate different cultural rearing patterns. Different cultural values is a factor which ethnic minority members such as Padilla and his colleagues forcefully argue (Padilla, et al, 1975). Stoker and Meadow state that for the Mexican-American child "controls are externalized as contrasted with the typical Anglo-American child rearing patterns which place emphasis on personal conscience and on repressive defenses" (Stoker and Meadow, 1974, p. 198).

According to the case reports studied by Stoker and Meadow, disturbed Mexcian-American boys consistently exhibited symptom patterns of fighting (34%),

hostility (45%), hyperactivity (24%), impulsivity (20%), negativism (24%), obstinancy and defiance (24%), stealing (36%), truancy (17%), dropping out of school (11%), and temper tantrums (22%). It is clear to this reviewer that all of these symptoms help constitute a pattern of social problems. The troubled Mexican-American boy is likely to be a problem for others. He is likely to generate problems for himself as well because his problematic behavior to others contributes to greater difficulties of a social nature which threaten Mexican-American males: unemployment, illiteracy, little or poor education, and high rates of arrest and incarceration.

Stoker and Meadow focus on the school drop-out pattern as a matter of major significance for these Mexican-American children who were clinic cases. Eleven per cent of the Mexican-American boys and 7% of the girls dropped out of school as compared to 1% of the Anglo-American boys and 4% of the Anglo-American girls.[14] Stoker & Meadow draw attention to the fact that the majority of Mexcian-American children, especially the boys, who had dropped out "were not old enough to be able to legally" do so (Stoker and Meadow, 1974, p.199).[15] It might be instructive for the reader to know that 81% of the Mexican-American boys, 68% of the Mexican-American girls, 83% of the Anglo-American boys, and 75% of the Anglo-American girls were between the ages of seven and 16, that is, of school age.

Increased reading skills and increased school attendance might go a long way in alleviating the social problems which poor education has meant for Mexican-Americans. Two counselors (Hosford and Bowles, 1974) have reported on a project to help solve a school district's reading problems. The district had a large number of Spanish surnamed children in school.

[14] N=76 for each sex in the ethnic groups.

[15] The social nature of this school drop-out pattern is made clear when seen against the background of its economic impact.

> *(When) a particular segment of citizens continues to produce an abnormally large percentage of poorly educated children, the economic problems of not only the subcultural groups but of the entire area become intensified. Industry will not move to areas where it will be unable to secure a complement of trained or potentially trainable workers, completing the cycle of poverty (Stoker and Meadow,1974, p. 199).*

All 136 children in fourth, fifth, and sixth grade reading instruction programs were matched according to current reading level (low, medium, high). The investigators placed each child at random into either a control or experimental group of her reading level. Children in the experimental groups were allowed to choose among certain activities whenever they engaged in a reading behavior seen as desirable. Children in the control groups received the same reading program as the other children, but special activities were not available as reinforcers.

This reviewer wishes to concentrate on the manner in which reinforcers were identified, what they were, and how they were used by the children.[16] It is probable that the principle being employed in the reading program has implications for other behavior and other settings in which Chicano children engage.

The investigators decided to identify reinforcers by observing the children when they engaged in free time activity. The students were observed at home, at play, and at school. Seventeen items were finally selected as appropriate, and the children frequently chose nine. These nine items are described in Plate I. The descriptions are from Hosford and Bowles, 1974.

[INSERT PLATE I ABOUT HERE]

[16] The program to improve reading proved of significant success for students in the experimental groups.

Plate I

Nine Reinforcers Chosen Frequently by Mexican-American and Anglo-American Children

1. Certificate - The certificate has elaborate printing and states: "(student's name) has worked hard in reading this week." It has four spaces where star seals are placed when earned. On the day the student selects this item, his name is printed in the blank space, and he receives one star. The certificate is kept at school until he has earned four stars. It is then "official" and may be taken home.

2. Play games - Checkers, chess, Password, Scrabble, football game, etc. For a game requiring two persons, each one must earn the right to select that item). A wide variety of games were stocked in each experimental classroom. Because these games could be played at times other than when earned by demonstration of particular reading behaviors, the potency of this particular reinforcer may have been somewhat attenuated.

3. Beads for making wampum and necklaces (six beads each day). This reinforcer allowed the student to engage in an activity over a period of time, thus providing for immediate reinforcement as well as delayed reinforcement when the wampum or necklace was completed.

4. Color or draw with crayons, chalk, or pencil.

5. Work on mosaics.

6. Pencil to keep.

7. Marbles to keep - Many boys and girls in the school district played marbles during recess periods.

8. Tape recording-stories and history of the people of Old Spanish California and Mexico (listen on earphones) — These recordings included readings taken from The First Book of Mexico by Sam and Beryl Epstein (New York: Franklin Watts, 1955).

9. Comic books (e.g., Archie, Batman, Superman) — A student could win the opportunity to read one comic book per day. If he were unable to finish reading it in the time allotted, he was asked to earn the reinforcer the next day in order to complete it. The use of Spanish-language comic books was another attempt to generate an ethnically valued reinforcer for Spanish-surnamed students.

Adapted from Hosford and Bowles, 1974.

Hosford and Bowles had considered eight items as likely to be reinforcing, but the children's choices did not indicate the eight items had reinforcing properties. These eight items were: sit quietly at desk and do nothing, talk with a friend, keep an eraser, listen to tape recordings of stories of the people of Old Spanish California, listen to tape recordings of stories of American pioneers, listen to music of Mexico, listen to popular music, look at comic books written in Spanish, and choose an item not listed. (Hosford and Bowles, 1974).

Differences in use of reinforcers were noticable along sex lines much more than along cultural lines. Reinforcers thought to reflect specific Chicano values and interests were not chosen more often by Chicanos than by Anglos, in fact, Hosford and Bowles report that these "Chicano culture" reinforcers were selected less often than the majority of other possibilities (Hosford and Bowles, 1974).

As state above, nine items werechosen significantly more than the rest. Sex differences constitute a pattern of choice in all of the nine items. On one item ethnic differences also came into play. Reading ability plays a part in one choice (Hosford and Bowles, 1974). These nine items and their pattern of choices are listed in Table V.

[INSERT TABLE FIVE HERE]

TABLE V

Patterns of Choice of Items Chosen Often by Mexican-American and Anglo-American Children

Item #	Item	Chosen significant by
1	Certificates	Females more than males.
2	Play games	Males more than females.
3	Beads	Females more than males; high ability groups more than medium or low groups.
4	Color or draw	Females more than males.
5	Work on mosaics	Females more than males.
6	Keep pencils	Males more than females.
7	Keep marbles	Anglos more than Chicanos; males more than females.
8	Listen to old Spanish stories	Males more than females.
9	Read comic books	Males more than females.

Adapted from Hosford and Bowles, 1974.

One result of this program to improve reading skills has significance for improving the educational level of Chicano students overall. The authors report that Chicano students allowed to choose reinforcements had better school attendance records than the Anglo and Chicano students in the control groups. Hosford and Bowles (1974, p. 299) state that this result "suggests that the reinforcement procedures might be expanded to other subjects and to social and interpersonal behavior." [17]

[17] Blackham and Silberman (1975) report similar encouraging results with Mexican-American high school students. See pp. 155-57 of their book.

STUDIES PERTINENT TO LOWER SOCIOECONOMIC LEVEL

(Without Significant Mention of Minority Cultures)

Abstract

This section reports research material whose subjects are identified predominantly as lower socioeconomic. This classification appears in all cases to be a matter of family income.

Three researchers (Glidewell, Mensh, and Gildea, 1957) report a project designed to identify children with behavior disturbances. They asked mothers to identify whether their children exhibited any of twenty specified symptoms; frequency, severity, and duration of observable behavior symptoms were probed as well. The researchers report a reliable, positive relationship between mothers' reports and independent clinical assessments of children. The report appears to have preceded a more extensive study by one of the authors (Glidewell, 1969).

One of the above researchers (Glidewell, 1969) reported extensively about the prospects of using a mother's report of her child's behavior symptoms. Over a three and one-half year period, he gathered data on 829 children. He used the same symptom list as used in the article co-authored in 1957 with Mensh and Gildea. This time mothers' ratings of children were paired with teacher's ratings of pupil adjustment. The author reports the relative prevalence of symptoms and the rare incidence of new symptoms after age ten. Antisocial behavior was quite rare, and few significant sex or social class differences were observable.

Two researchers (O'Neal and Robins, 1958) conducted a thirty-year follow-up study of persons seen as patients in a child guidance clinic. They identify certain behavior which distinguishes pre-schizophrenic children from normal children. They emphasize the strong correlation they found between childhood antisocial behavior and adulthood schizophrenia.

One researcher (Kiev, 1970) reports on anthropological inquiries into schizophrenia. He reports only four of twenty-six symptoms appear to be nuclear features of schizophrenia regardless of culture. One of these features is flatness of affect.

Flatness of affect and the inability to invest emotionally in others are reported as outcomes of what is commonly called "maternal deprivation" (Bowlby, et al, 1956; Bowlby, 1958; Coleman, 1972). Two investigators (Richmond and Lipton, 1961) report contrasting views of the matter. The term "maternal deprivation" itself is discussed. The outcomes of "maternal deprivation" are discussed in relation to delinquency, antisocial behavior, and adult behavior disturbances such as schizophrenia and sociopathic personality.

Two studies done by John Glidewell contain pertinent data for this essay. One study (Glidewell, Mensh, and Gildea, 1957) appears to have contributed to a final report (Glidewell, 1969) sent to this reviewer by the author. Separate discussion of each study precedes a comparative look at their data.

Glidewell, Mensh, and Gildea (1957) studied childhood behavior symptoms and their relationship to disturbance. The behavior symptoms were reported by mothers, and disturbance was determined by professional clinicians. All of the children were White, ninety-one were third-grade public school children, and thirty-five, who were the same age as the other children, were cases in a St. Louis County child guidance clinic. Although the authors report the sex breakdown of the school children, they do not provide the same information for the child guidance clinic patients. On reflecting upon the study, this reviewer has concluded that the thirty-five clinic subjects did not provide the authors with their need for more information about disturbed children. Although the thirty-five clinic patients were added to increase the total number of disturbed children in the sample, reported findings give no details about these thirty-five children added to the study. This reviewer believes that results based on the ninety-one subjects provided a preliminary report from which Glidewell decided to study the phenomenon more closely: promising results justified more extensive research.

The authors (Glidewell, Mensh, and Gildea, 1957) employed four categories of disturbance to classify data about the children's degree of sickness. These four categories were: well-adjusted, no significant problems, sub-clinically disturbed, and disturbed. A child judged to be well-adjusted in

interpersonal relationships and personal accomplishments fits the first category. A happy child judged to get along well with others and to accomplish reasonably well tasks related to her age and level of development, fits the second category. A child judged to be not so happy as he might be and to experience moderate difficulties in maturing, fits the third category. A child judged to have or likely to have serious adjustment problems which require clinical help, fits the fourth category.

The ninety-one third graders were judged to include twenty-one well adjusted children, thirty-nine with no significant problems, twenty-five subclinically disturbed, and six disturbed. The thirty-five child clinic patients were judged to include two with no significant problems, fourteen subclinically disturbed, and nineteen disturbed (Glidewell, Mensh, and Gildea, 1957).

The authors reported a reliable, positive relationship between the number, frequency, duration, and severity of symptoms reported by a child's mother and the degree of sickness found in the child. Investigators asked mothers if their children had any trouble with eating, sleeping, other children, digesting food, grownups, unusual fears, nervousness, thumbsucking, over-activity, sex, daydreaming, temper tantrums, crying, lying, stealing, destructiveness, rejection of school, wetting, speaking, or motion sickness. If mothers gave an affirmative answer to a symptom, the interviewer probed into the specific difficulty, its duration, its frequency, and its severity (Glidewell, Mensh, and Gildea, 1957).

To determine the findings of the study, the authors mention that they took into account sex, age, socioeconomic level, and school variables. They report findings only according to sex, however. They conclude that the degree of sickness related in a positive, stable, clear-cut pattern with the number, frequency, duration, and severity of symptoms reported by a child's mother. In fact, the authors maintain that the likelihood of childhood behavior or emotional disturbance increased as the number of reported symptoms increased (Glidewell, Mensh, and Gildea, 1957).

The following table indicates a breakdown of number of symptoms and degrees of sickness for the ninety-one school children. The authors did not provide information for the thirty-five clinic cases (Glidewell, Mensh, and Gildea, 1957).

[INSERT TABLE VI HERE]

Table VI shows that 23 children were reported to exhibit one symptom or less. Twenty-one of these children (91.3%) were judged to be well-adjusted or have no significant problems. The authors (Glidewell, Mensh, and Gildea, 1957) regarded this as a high percentage of accuracy. The association between level of adjustment and reported numbers of symptoms is given in Table VII.

[INSERT TABLE VII HERE]

TABLE VI

Number of Symptoms and Degrees of Adjustment

No. of Boys		No. of Symptoms			
		0-1	2-3	4-6	7+
4	(a) well-adjusted	3	1	0	0
24	(b) no significant problems	10	6	7	1
14	(c) subclinically disturbed	0	5	9	0
5	(d) disturbed	0	2	0	3
N = 47		13	14	16	4

No. of Girls					
17	(a) well-adjusted	4	8	5	0
15	(b) no significant problems	4	6	5	0
11	(c) subclinically disturbed	2	3	4	2
1	(d) disturbed	0	0	0	1
N = 44		10	17	14	3

Adapted from Glidewell, Mensh, and Gildea, 1957.

TABLE VII[1]

Association Between Level of Adjustment And

Number of Reported Symptoms

No. of Symptoms	0-1	3 or less	4-6	4 or more	7 or more
Adjusted	91.3%	78%	56.7%	48.6%	14%
Disturbed	8.7%	22%	43.5%	51.4%	86%
	(23)	(54)	(36)	(37)	(7)

[1] Figures in parentheses = Number of children.

Adapted from Glidewell, Mensh, and Gildea, 1957.

As Table VII shows, the authors' ability to identify adjusted or disturbed children increased when a few symptoms or many symptoms were used as standards for predicting childhood adjustment or disturbance. The middle range of reported symptoms offered less assessment reliability. However, at either extreme of the scale it appears evident that accuracy increased. When healthy behavior is linked to the presence of few symptoms (three or less) or when disturbed behavior is linked to several symptoms (seven or more), the authors appear to have demonstrated some prognostic value for the gathering of data from mothers about their children. However, unless a much larger sample were studied it seems that no definitive conclusions about the findings could be generalized.

Glidewell (1969) published a much more extensive and thorough research study about the prospects of using a mother's report of her children's behavior symptoms. He studied 829 third-grade children. In the earlier report, he and his colleagues studied ninety-one[18] children. Interviewers used the same symptoms[19] as used in the earlier study when talking to mothers about their children. Investigators probed the specific nature of a symptom, its frequency, its duration, and its severity. This time, in addition to gathering mothers reports, the interviewer asked teachers to give ratings of the children's level of adjustment (Glidewell, 1969).

[18] 35 if the thirty-five clinic cases are included.

[19] See p. 41 of this essay. Motion sickness, however, was the one symptom not included in the later study.

In the opinion of this reviewer, a similarity in research design appears to exist between Glidewell's study and the similar work of Schiff and Kellam in Woodlawn.

Glidewell provided data about sex and socioeconomic level as related to symptoms, adjustment, and maladjustment. He did not provide information about ethnic and/or racial characteristics in this later study. Census information indicates that 95.8% of St. Louis County residents at the time of Glidewell's study were White.[20] Of the 406,349 people in St. Louis County in 1950, their sexual and racial characteristics broke down in the following manner:

White males	-	190,484
Black males	-	7,910
other males	-	111
White females	-	198,852
Black females	-	8,909
other females	-	83

After the initial investigation of the third graders, Glidewell studied the 829 children during the twelve months between the fourth and fifth grades and during eighteen months after fifth grade. In all, the study lasted nearly three and one-half years, from the entrance into third grade until the children had entered seventh grade. The study's follow-up procedures and its large sample are two of this study's striking qualities.

A relative prevalence of symptoms manifested itself. Eating trouble appeared in about 32% of the children (266). Nervousness, an all-inclusive term which Glidewell said may indicate a number of different symptoms, was reported in the same number of children.

[20] Census data gained from U. S. Government census statistics for 1950.

Daydreaming, temper tantrums, and unusual fears appeared in 20% of the children (166). Glidewell (1969) questioned whether these three symptoms could be merely manifestations of immaturity. He noted that symptoms such as frequent crying and wetting self, which could also be manifestations of immaturity, were less prevalent.

Trouble getting along with other children, wetting self, over-activity, lying, and frequent crying appeared in 15% of the children (124). Glidewell looked for but could find no common basis for the similarities in prevalence of these symptoms.

Ten per cent of the children (83) manifested speech problems, thumbsucking, sleep problems, and stomach trouble. Glidewell (1969) pointed out the clear relationship between these problems and such routine areas of functioning as communication, sleep, and digestion.

Other than lying, antisocial symptoms showed a low prevalence. Only 2% to 5% of the children (no more than 41) manifested trouble getting along with adults, destructiveness, making a fuss about going to school, sexual trouble, and stealing. This reviewer suggests antisocial symptoms be seen as early signals of deviance: since the symptoms are rarely prevalent among children, should not their presence raise signal flags for clinicians about incipient pathology? O'Neal and Robins (1958a) have raised this question, and Robins' (1966) study of sociopathic personality would support the conclusion that, indeed, antisocial symptoms are harbingers of pathology.

Numerous tables in Glidewell's study (1969) provide data about differences between sexes, socioeconomic levels and adjustment ratings. The following tables have been adapted from Glidewell (1969). Glidewell's tables contained information on twenty-one symptoms. This reviewer's tables contain information on only those symptoms which significantly differentiate sexes, socioeconomic levels, or adjustment ratings.

[INSERT TABLES VIII, IX, AND X HERE]

Studies of the incidence of symptoms indicate that differences between males and females were small and without statistical significance. Although unusual fears appeared among girls with significantly higher prevalence, Glidewell (1969) said the symptom was present among both boys and girls with no significant difference in incidence. Socioeconomic differences were negligible, although middle socioeconomic level boys seemed to have had more trouble with symptoms of withdrawal than did other children (Glidewell, 1969). Data in Table X tends to confirm the earlier finding of Glidewell, Mensh, and Gildea (1957) that disturbances were more likely to be present when several symptoms were present. It is instructive that several symptoms significantly differentiated one group from another only when the groups' adjustment ratings were compared.

As the investigators studied children from one period to the next,[21] they were struck by "the sharp drop in new symptoms from the first period to the next" (Glidewell, 1969, p. 199). There seems support, therefore, that between a child's ninth and tenth year "significantly fewer new behavior symptoms appear" (Glidewell, 1969, p. 199), and, as an inference by this

[21] Third grade, 4th grade, 5th grade, 6th grade, 7th grade.

TABLE VIII[1]

Symptoms Significantly Different ($p < .02$) for Boys and Girls

Symptom	Rates per 100 Boys	Rates per 100 Girls
Unusual fears	13	25
Trouble getting along with other children (withdrawal)	15 (06)	19 (09)

[1]Corrected for socioeconomic level and maladjustment effects.

Adapted from Glidewell, 1969.

TABLE IX[1]

Symptoms Significantly Different ($p < .05$) for Socioeconomic Levels

Symptom	Rates per 100	
	Middle Classes	Lower Classes
Trouble getting along with other children (withdrawal)	18 (08)	15 (07)

[1] Corrected for sex and maladjustment effects.

Adapted from Glidewell, 1969.

TABLE X[1]

Symptoms Significantly Different ($p < .02$) for Adjustment Ratings

	Rates per 100	
Symptom	Adjusted	Maladjusted
Nervousness	29	42
Daydreaming	17	28
Trouble getting along with other children	11	31
(withdrawal)	(04)	(15)
(acting out)	(06)	(16)
Overactivity	11	22
Trouble sleeping	06	15
Destructiveness	04	12

[1]Corrected for sex and socioeconomic level effects.

Adapted from Glidewell, 1969.

reviewer, that attention should be focused on children before they are ten. Many studies emphasize that a child's sixth to tenth year marks a critical period for her development. (Kagan, 1966; Sobel, 1975; Kagan and Moss,1962; Robins, 1966).

O'Neal and Robins (1958) did a follow-up study of 284 persons seen in a child guidance clinic thirty years previously. Two-hundred and ten were males, and seventy-four were females. O'Neal and Robins discovered that twenty-nine of the 284 persons had been diagnosed schizophrenic as adults; twenty-seven of these twenty-nine were males. The difference between male presence in the total population (74%) and male presence in the schizophrenic (93%)[22] is enough to understand the label of "young man's disease" formerly applied to schizophrenia.

Fifty-eight of the 284 persons were diagnosed as having no behavior disorders as adults; fifty-one were male, and seven female. The authors determined that this difference, as the one found for male/female schizophrenia, was statistically significant at the .01 level (O'Neal and Robins, 1958).

O'Neal and Robins compared factors in the history of the schizophrenic and the no disease groups. They wished to identify, if possible, significant prognostic factors in the development of schizophrenia (O'Neal and Robins, 1958).

As children, the subjects' socioeconomic level was predominantly low or lower middle. Both groups indicated a high rate of broken homes as children. These factors did not differentiate the pre-schizophrenics from the no disease group. O'Neal and Robins, did not report racial or ethnic classifications (O'Neal and Robins, 1958).

[22] $p<.01$

In contrast to the no disease group, pre-schizophrenic children exhibited the following symptoms: severe infectious disease in infancy, walking difficulties, hearing problems, disfigurement, feminine appearance for boys, physical aggression, pathological lying (that is, with no apparent motive), incorrigibility, disobedience, eating disturbances, overdependency on mother, fears, depression, and chronic unhappiness. Four of these symptoms are manifestations of antisocial behavior (O'Neal and Robins, 1958).

The authors noted that few researchers have linked antisocial behavior patterns to children who are pre-schizophrenic or schizophrenic. They believe that such behavior patterns could signal the investigator to examine the child's psychiatric status. They maintain that recognition of antisocial symptoms would be an important initial step in treatment for pre-schizophrenic children (O'Neal and Robins, 1958). Furthermore, it seems valid to conclude from O'Neal and Robins' data, that multiple symptoms are possible early signals of schizophrenia in any child.

O'Neal and Robins made four conclusions from their data. One, in childhood the schizophrenic adults had more symptoms of all kinds - including antisocial behavior - than did the no disease group. Two, more functional areas were disturbed in the pre-schizophrenic child than in the child who had no psychiatric problem as an adult. Three, as adults the schizophrenic group had a higher rate of mental hospitalization than the no disease group. Four, because schizophrenic adults have a higher arrest rate than the no disease group, schizophrenics are often treated as criminals rather than as mentally ill persons (O'Neal and Robins, 1958).

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Anthropologists have recognized for some time that specific psychiatric disorders have both culturally conditioned aspects and essential aspects (Kiev, 1970). A worldwide survey uncovered twenty-six symptoms reported as symptomatic of schizophrenia; however, only four of the twenty-six were reported as very common. These four symptoms were social and emotional withdrawal, auditory hallucinations, illusions, and flatness of affect.

These four symptoms would appear from the data reported by Kiev to be nuclear features of schizophrenia. They appear to be symptoms of schizophrenia generalizable across cultures. If Kiev's report is accurate, behavior such as auditory hallucinations, illusions, emotional withdrawal, or flatness of affect would be indicative of schizophrenia and would provide some key variables which might be used in a needs assessment. At the same time, if members of a specific culture were to report such behaviors as "normal," such a report would at least appear to be unusual when matched with the data reported by Kiev.

Flatness of affect and inability, two of the nuclear features of schizophrenia, are presented as outcomes of what investigators call "maternal deprivation" (Bowlby et al, 1956; Bowlby, 1958; Coleman, 1982). Richmond and Lipton (1961) present some studies with contrasting opinions regarding the significance of maternal deprivation. However, Richmond and Lipton caution against considering these contrary findings definitive since they do not evaluate personality variables nor present longitudinal findings. Coleman (1972,

p. 148) maintains that "available evidence leaves no doubt that maternal deprivation can seriously retard intellectual, emotional, social and even physical growth.[23]

Although accepted in psychiatric circles as the term to describe the phenomenon under discussion, maternal deprivation is a misnomer. The evidence indicates that a child needs attention and stimulation from a significant individual. This person can be the child's father, uncle, mother or even a non-relative. The important factor is someone's continuous attention, warmth and stimulation to the child. Thus, although this essay uses the term "maternal deprivation," it does not restrict the phenomenon to a child's early separation from her mother or to inadequate mothering. In some situations "paternal deprivation" would accurately convey the fact that a father has been responsible for providing attention but has neglected his child in some significant manner. However, no research studies appear to have studied "paternal deprivation."

Although usually discussed as a factor in infancy, especially the first six to eighteen months, maternal deprivation is being considered in this essay because of its prognostic value for childhood behavior disorders. The "affectionless character," incapable of forming relationships with others, is prone to delinquency and antisocial behavior. Delinquency and antisocial behavior are symptoms of adult behavior disturbances such as sociopathic personality and schizophrenia (Caplan and Douglas, 1969; O'Neal and Robins, 1958; Robins, 1966; Frank, 1966).[24]

[23] A current article reports research on mother-child interaction and mothers' personal histories. No significant difference was found between mothers of children who thrive and mothers of children who fail to thrive when measured for: 1) presence or absence of parental psychiatric hospitalization, 2) mother's marital status at time of giving birth, 3) changes in marital status (Pollitt, Eichler, and Chan, 1975). The evidence calls for further research on the effects of maternal deprivation.

[24] The essay includes information concerning delinquency in the catchment area and in Maricopa County. See pp. 56-91.

DELINQUENT BEHAVIOR: MARICOPA COUNTY AND THE CATCHMENT AREA

Abstract

One researcher (Robins, 1966) presents data regarding the development of sociopathic personality. She completed a longitudinal study which matched one hundred adults seen as patients when children and one hundred control subjects. Childhood theft is the behavior most predictive of sociopathic personality development. She lists thirteen other symptoms found to be good predictors. Socioeconomic level did not significantly influence the development of sociopathic personality. Robins reported that a father's psychiatric status is the major home influence upon development of sociopathic behavior. She cautions against designing programs to prevent sociopathy by removing poverty, gangs, or slums.

A lengthy section of material focuses on data about delinquent behavior in Maricopa County and in the catchment area. Information is presented concerning juvenile arrests, juvenile referrals, and child-set fires in 1973. Other information reports the following data:

1. *Total delinquency referrals by age for 1970, 1972 and 1974.*
2. *Rank order of offenses for children 8-12, 1972, 1973 and 1974.*
3. *Rank order of offenses for children 8-12 by sex, 1972, 1973 and 1974.*
4. *Detention by ethnicity and sex for 1972 and 1974.*
5. *Delinquency referrals by age per 1,000 children, 1970, 1972, and 1974.*
6. *Delinquency referrals by ethnicity from the catchment area, 1974.*
7. *Referrals by sex, ethnicity, and census tract, 1974.*
8. *Projected delinquency referrals for Maricopa County, 1976 and 1980.*

Children And Sociopathic Personality

A book-length longitudinal study of sociopathic personality (Robins, 1966) provides important data concerning delinquent behavior of children. Of 382 males and 142 females (524) seen as children in a child guidance clinic, Robins successfully obtained information thirty years later concerning 350 males and 123 females. She matched 100 controls by age, sex, socioeconomic status, IQ, and race, and matched that data with information about 69 male controls and 29 female.[25] All of the patients and controls were white. The preponderant majority (72%) of the patients were from lower socioeconomic families; 19% were from middle socioeconomic, and 9% were not able to be classified (Robins, 1966).

Robins' data allows for conclusions regarding differences of antisocial symptoms in males and females. Sociopathic behavior and juvenile antisocial symptoms were exhibited by males almost exclusively. Ninety-four of the child guidance patients were diagnosed sociopaths as adults; eighty of these were males.

Boys referred to the clinic for theft developed sociopathic personalities as adults significantly more than did boys referred for all other reasons. Insubordination to persons in authority was seen as another important sign of incipient sociopathic personality. Although a rare reason for the referral of girls, theft held the same predictive value for sociopathic development as it did for boys. For girls, sexual behavior was the only reason for referral which predicted adult sociopathic personality at a statistically significant rate higher than referral for non-antisocial behavior. At the same time, however, boys referred for sexual problems had a good chance for healthy behavior as adults.[26]

[25] Male/female differences will be discussed immediately below.

[26] Robins noted that sexual mores have changed considerably since the 1920's and 1930's. She questions whether sexual behavior under current mores would hold the same predictive value for girls and

The following fourteen symptoms were found to be predictive of sociopathic personality. Inability to hold a job, incorrigibility, staying out at night beyond the hour permitted, physical aggression, associating with children of bad reputation, markedly impulsive and reckless behavior, truancy, running away from home or sleeping out without permission, lying without apparent motive, lack of guilt about antisocial acts, thefts, verbal aggression, sexual perversion, and illicit heterosexual relations. Only 5% of the children with 10 of these antisocial symptoms were considered well as adults ($p < .001$). Seven of the symptoms were significantly present among young sociopaths who ranged from 8 to 14 plus. These seven symptoms were: lying without apparent motive, lack of guilt, recklessness, sexual perversion, incorrigibility, staying out late, and bad companions. Evidence clearly indicated that juvenile antisocial behavior points to adult adjustment problems, whose severity is predictable from the severity of the child's antisocial behavior (Robins, 1966).

The effects of juvenile antisocial symptoms upon adult behavior is made strikingly clear when the following longitudinal results are considered. Robins (1966, p. 143) states that "in subjects without a significant number of juvenile antisocial symptoms, about one-fourth were well as adults even when they had a high rate of non-antisocial symptoms (for example, phobias, enuresis after age six, tantrums, or chronic irritability) as children. <u>But once the child had six or more antisocial symptoms, the addition of non-antisocial symptoms had no</u> effect on the proportion well as adults." (emphasis added).

Socioeconomic level as a child did not correlate significantly with development of sociopathic personality; however, blue-collar families did contribute slightly more children who were diagnosed sociopathic personalities as adults. The significant factor upon the child appeared to be his father's

psychiatric rather than socioeconomic status. The investigators found the same predictors of sociopathic personality regardless of whether as children the adults had come from middle socioeconomic level or lower socioeconomic level homes. Robins (1966) suggests that the presence of high numbers of lower socioeconomic level sociopaths is due to variables such as inability to retain a job, squandering money, and insubordination to authorities. The effects of modeling thereby come into play: lower socioeconomic level children develop antisocial behavior modeled for them by the significant adults, especially fathers, in their lives.

The lack of correlation between sociopathic personality development and social class hold implications for preventive programs. Robins cautions against instituting programs to achieve goals beyond program capabilities. She says,

> *Although we cannot rule out social status as having contributed to the child's original antisocial behavior, we do know that in the absence of antisocial behavior in childhood and an antisocial father, lower social status does not predict severe and pervasive adult antisocial behavior. Families can live in slums and be on relief rolls without their children's responding to the frustrations of poverty or to the examples of delinquency in their neighborhoods with sociopathic behavior if the families' poverty stems from the death or disability of their breadwinners rather than from their antisocial behavior. It is unreasonable, then, to attribute a crucial role in the production of adult antisocial behavior to the frustrations consequent to low prestige and poverty in childhood. The practical implication of this conclusion is that there is little hope of preventing sociopathy through slum clearance, more adequate relief payments, or the breaking up of juvenile gangs. While an improved level of living for the poor is unquestionably a humane goal in its own right, it should not be expected materially to reduce the numbers of criminal, alcoholic, and maritally unstable persons in the population (Robins, 1966, p.198).*

Delinquency Referrals in the Catchment Area And Maricopa County

Certain 1973 data regarding delinquent behavior in the catchment area are already available in a study done by the Phoenix South Community Mental Health Center's Research Department. (Wignall, 1975). These data can be broken down into several specific categories. First to be considered will be juvenile arrests and some specific charges by the Phoenix Police Department, second will be active cases and referrals handled by the Department of Corrections, and third will be child-set fires reported by the Phoenix Fire Department.

[INSERT TABLE XI HERE]

Other than active juvenile cases handled by the Department of Corrections, none of the data has been broken down by sex. Ethnic, socioeconomic, and racial characteristics were not reported for any of the data. (Wignall, 1975). Data compiled by the Maricopa County Juvenile Court Center report offenses by age and sex for the years 1972, 1973, and 1974 (Maricopa County Juvenile Court Center, 1973; 1975). Male and female ethnic breakdowns appear for the year 1972 in the Juvenile Court Center's report. Delinquency referrals for 1976 and 1980 are projected.

The Maricopa County Juvenile Court Center (Supplemental Report #13, 1975) noted that dramatic increases begin to occur as the children reach their 12th year or enter the early teens. Such variations are immediately apparent when the total delinquency referrals by age are noted.

[INSERT TABLE XII HERE] 68

TABLE XI

1973 Juvenile Arrests, Cases, and Child-set Fires
Catchment Area

I.	Juvenile arrests (ages 10-19	8,418
	a. burglary	740
	b. narcotics	236
	c. glue/paint sniffing	207
	d. runaways	1,192
II.	Juvenile cases (ages 10-19)	491
	a. males	390
	b. females	101
	c. referrals	5,185
III.	Child-set fires (ages 4-14)	295

Adapted from Wignall,1975.

TABLE XII

Total Delinquency Referrals by Age[1]

Maricopa County

AGE	1970	1972	1974
8	186	199	170
9	300	324	261
10	436	490	444
11	627	733	635
12	1,096	1,142	1,040
13	1,745	1,694	1,681
14	2,562	2,498	2,523
15	3,204	3,157	3.091
16	3,723	3,537	3,884
17	3,521	3,519	4,320
Total	17,400	17,293	18,049

[1] 1971 was excluded from the analysis because of lack of reliable counts due to an abortive attempt to computerize. In 1973, methods of counting were changed at the beginning of the year. Offense breakdown for this year indicate that some referrals may have been missed and therefore 1973 was not included.

Adapted from Maricopa County Juvenile Court Center, Supplementary Report #13, p. 2.

1972-1974 data are presented below (Tables XIII-XXI) in terms of specific offenses committed by male and female children ages seven and under to twelve. The Juvenile Court Center (Supplemental Report #1, 1973; Supplemental Report #8, 1974; Supplemental Report #12, 1975) listed the data for specific offenses in rank order, viz. total number of offenses committed between the ages of seven and under to eighteen. This reviewer adapted the tables to report offenses of greatest frequency for children ages seven and under to twelve. Incorrigibility offenses and other referrals have also been included.

[INSERT TABLES XIII-XXI HERE]

TABLE XIII

1972 Delinquency Referrals in Rank Order by Age

OFFENSES	AGE						
Delinquent	Seven and under	8	9	10	11	12	Total
Petty theft	38	54	109	189	269	478	1,137
Burglary	19	47	61	101	137	182	547
Vandalism, Malicious mischief	45	55	80	103	126	134	543
Disorderly conduct	5	10	11	20	30	60	136
Trespassing	5	3	15	7	23	30	83
Assault, Aggravated	3	3	11	12	21	28	78
Arson	18	9	7	6	23	18	81
Incorrigibility Offenses[1]							
Runaway in State	41	41	54	61	116	260	573
Incorrigible	1	1	8	15	34	85	144
Runaway out of State		1			1	4	6
Truancy	4	5	6	9	14	40	78
Other Referrals							
Other			9	8	18	23	58
Courtesy Hold (SDOC)				1	6	19	26
Dependencies	100	14	11	3	8	7	143
Offenses against family and children (victim)	38	8	6	7	13	10	82
Total	317	251	388	542	839	1378	3715

[1] These offenses are commonly called "status offenses" in several circles. The Juvenile Court Center consistently labels these offenses as "incorrigibility offenses" because a status offense technically must include any behavior illegal for children but legal for adults. Possession of tobacco is a status offense, for example.

Adapted from Maricopa County Juvenile Court Center, Supplementary Report #1.*

*No pagination in original.

TABLE XIV

1972 Overview of Male Referrals

OFFENSES	AGE						
Delinquent	Seven and under	8	9	10	11	12	Total
Petty theft	46	47	86	147	194	292	812
Burglary	14	40	55	82	127	168	486
Vandalism, Malicious mischief	40	54	76	97	118	128	513
Disorderly conduct	3	10	10	20	24	53	120
Assault, Aggravated	3	2	9	11	20	24	69
Trespassing	2	3	15	5	20	25	70
Arson	18	8	7	6	22	17	78
Incorrigibility Offenses							
Runaway in State	31	37	38	46	78	141	371
Incorrigible	1	1	6	10	21	51	90
Runaway out of State		1			1	2	4
Truancy	4	4	.6	7	8	30	59
Other Referrals							
Courtesy Hold (SDOC)				1	6	14	21
Other			8	7	17	18	50
Dependencies	75	9	4	3	2	6	99
Offenses against family and children (victim)	28	7	3	3	8	7	56
Total	265	223	323	445	666	976	2898

Adapted from Maricopa County Juvenile Court Center Supplementary Report #1.*

*No pagination in original.

TABLE XV

1972 Overview of Female Referrals

OFFENSES	AGE						
Delinquent	Seven and Under	8	9	10	11	12	Total
Petty theft	2	7	23	42	75	186	335
Burglary	5	7	6	19	10	14	61
Incorrigibility Offenses							
Runaway in State	10	4	16	15	38	119	202
Incorrigible			2	5	13	34	54
Runaway out of State						2	2
Truancy		1		2	6	10	19
Other Referrals							
Other			1	1	1	5	8
Courtesy Hold (SDOC)						5	5
Offenses against family and children (victim)	10	1	3	4	5	3	26
Dependencies	25	5	7		6	1	44
Total	52	25	58	88	154	379	756

Adapted from Maricopa County Juvenile Court Center, Supplementary Report #1.*

*No pagination in original.

TABLE XVI

1973 Delinquency Referrals in Rank Order by Age

OFFENSES	AGE Seven and under	8	9	10	11	12	Total
Shoplifting [1]	40	52	89	132	205	310	828
Malicious mischief	64	49	62	108	80	130	493
Burglary	49	28	49	80	126	140	472
Larceny, other	25	10	39	49	83	79	285
Disturbing peace	14	3	7	19	31	27	101
Curfew, loitering	6	1	8	2	27	48	92
Trespassing	4	7	12	10	18	36	87
Arson	23	13	7	9	21	6	779
Incorrigibility Offenses							
Runaway in State	40	14	45	70	98	252	519
Incorrigible	13	7	10	25	14	65	134
Runaway out State					1	3	4
Truancy	2	2	3	9	21	35	72
Other Referrals							
Other	41	14	9	25	15	53	157
Court ordered hold	4	1	9		14	12	40
Courtesy hold					2	1	3
Dependency	45	13	7	4	9	15	93
Courtesy Investigations	1	1		1	3	1	7
Total	371	215	356	543	768	1213	3466

[1] Personal communication with a researcher at the Juvenile Court Center clarified that 1972 data placed all shoplifting offenses under the "petty theft" category. Petty theft, however, includes offenses other than shoplifting. Shoplifting must occur within a building, but petty theft need not.

Adapted from Maricopa County Juvenile Court Center, Supplementary Report #8, p. 1.

TABLE XVII

1973 Overview of Male Referrals

OFFENSES	AGE						
	Seven and under	8	9	10	11	12	Total
Shoplifting	30	42	68	90	123	193	546
Malicious mischief	53	48	57	101	77	114	450
Burglary	43	27	43	72	115	128	428
Other Larceny	22	10	31	45	79	68	255
Disturbing the peace	13	2	7	17	28	22	89
Trespassing	4	7	11	7	13	31	73
Arson	22	13	6	9	18	5	73
Incorrigibility Offenses							
Runaway in State	18	10	35	49	62	131	305
Incorrigible	10	7	10	22	10	44	103
Truancy		2	3	8	16	21	50
Violation of probation	-	-	-	-	-	-	0
Runaway out State	-	-	-	-	1	1	2
Other Referrals							
Other	17	9	4	18	10	40	98
Court ordered held	4	-	9	-	14	12	39
Courtesy hold	-	-	-	-	2	1	3
Dependency	27	9	4	-	4	9	53
Courtesy Investigation	1	-	-	-	-	-	1
Total	264	186	288	438	572	820	2568

Adapted from Maricopa County Juvenile Court Center, Supplementary Report #8, p. 2.

TABLE XVIII

1973 Overview of Female Referrals

OFFENSES	AGE						
	Seven and under	8	9	10	11	12	Total
Shoplifting	10	10	21	42	82	117	282
Incorrigibility Offenses							
Runaway in State	22	4	10	21	36	121	214
Incorrigible	3	-	-	3	4	21	31
Runaway out State						2	2
Truancy	2	-	-	1	5	14	22
Violation of probation	-	-	-	-	-	-	0
Other Referrals							
Other	24	5	5	7	5	13	59
Court ordered hold	-	1	-	-	-	-	1
Dependency	18	4	3	4	5	6	40
Courtesy hold	-	-	-	-	-	-	0
Courtesy Investigations	-	1	-	1	3	1	6
Total	79	25	39	79	140	295	657

Adapted from Maricopa County Juvenile Court Center, Supplementary Report #8, p. 3.

TABLE XIX

1974 Delinquency Referrals in Rank Order by Age

OFFENSES	AGE						
	Seven and under	8	9	10	11	12	Total
Shoplifting	44	32	64	102	151	271	664
Burglary	37	43	58	121	134	217	610
Other Larceny	25	15	35	49	109	157	390
Malicious mischief	34	47	46	60	71	112	370
Trespassing	6	8	16	14	33	45	122
Arson	28	6	13	28	24	18	117
Disturbing the peace	7	3	7	13	20	32	82
Incorrigibility Offenses							
Runaway in State	41	27	49	67	106	222	512
Incorrigible	16	2	5	21	21	91	156
Runaway out State	—	—	—	—	4	6	10
Violation of probation	1	—	—	—	1	10	12
Truancy	2	1	5	9	9	22	48
Other Referrals							
Court ordered hold	5	—	—	6	17	29	57
Courtesy hold	—	—	—	—	—	5	5
Dependency	59	7	9	6	5	8	94
Other	6	—	—	2	1	1	10
Courtesy Investigations	7	—	—	—	2	1	10
Total	318	191	307	498	708	1247	3269

Adapted from Maricopa County Juvenile Court Center, Supplementary Report #12, p. 1.

TABLE XX

1974 Overview of Male Referrals

OFFENSES	AGE						
	Seven and under	8	9	10	11	12	Total
Burglary	31	37	53	113	123	209	566
Other Larceny	23	14	35	48	105	146	371
Shoplifting	32	28	48	73	101	125	407
Malicious Mischief	31	44	41	54	66	101	337
Arson	27	5	12	26	22	18	110
Trespassing	6	7	15	9	28	41	106
Disturbing the Peace	7	3	6	11	18	25	70
Incorrigibility Offenses							
Runaway in State	16	18	37	52	64	110	297
Incorrigible	15	2	5	13	13	62	110
Violation of probation	-	-	-	-	1	10	11
Truancy	1	1	5	8	8	8	31
Runaway out State	-	-	-	-	4	4	8
Other Referrals							
Court ordered hold	5	-	-	6	17	23	51
Courtesy hold	-	-	-	-	-	5	5
Dependency	34	4	4	6	5	3	56
Other	6	-	-	2	1	1	10
Courtesy Investigations	5	-	-	-	2	1	8
Total	239	163	261	421	578	892	2554

Adapted from Maricopa County Juvenile Court Center, Supplementary Report #12, p. 2.

TABLE XXI

1974 Overview of Female Referrals

OFFENSES	AGE						
	Seven and under	8	9	10	11	12	Total
Shoplifting	12	4	16	29	50	146	257
Incorrigibility Offenses							
Runaway in State	25	9	12	15	42	112	215
incorrigible	1	-	8	8	29	116	162
Runaway out State						2	2
Truancy	1	-	-	1	1	14	17
Violation of probation	1	-	-	-	-	-	1
Other Referrals							
Court ordered hold	-	-	-	-	-	6	6
Dependency	25	3	5	-	-	5	38
Courtesy hold	-	-	-	-	-	-	0
Courtesy Investigations	2	-	-	-	-	-	2
Other	-	-	-	-	-	-	0
Total	67	16	41	53	122	401	700

Adapted from Maricopa County Juvenile Court Center, Supplementary Report #12, p. 3.

Tables XIII-XXI clearly indicate that boys were referred for many offenses at a much higher frequency than were girls. The pattern of these sex-linked referrals is strikingly evident when the male referrals are compared to the female referrals. A high incidence of female referrals comprised but one offense, shoplifting, whereas the high incidence of male referrals comprised shoplifting, burglary, malicious mischief, other larceny, disturbing the peace, arson, and trespassing. In one year, 1972, there was a moderate incidence of male referrals for aggravated assault and female referrals for burglary. In all, it is clear that males and females differed in frequency of referrals except for petty theft, especially shoplifting, the offense of greatest incidence for both sexes over the three year period.

The tables present conflicting evidence regarding certain incorrigibility offenses. The number of annual male and female referrals for incorrigibility, truancy, and courtesy holds do not always sum to the total given by the Juvenile Court for each year. Such discrepancies cause questions to be raised regarding the tables. It would seem that some data are incorrect.

Information about referrals and/or detention by ethnicity and sex are available for the years 1972 and 1974. The 1972 data have been taken from the report of the Maricopa County Juvenile Court Center (Supplemental Report #2, 1973). The 1974 data were compiled by the Bureau of Preventive Services, which is a division of Arizona State Department of Corrections. The Bureau of Preventive Services sent these 1974 data to the present writer after a telephone contact.

[INSERT TABLES XXII, XXIII, XXIV, AND XXV HERE]

TABLE XXII

1972 Male Detentions by Ethnicity

Maricopa County

	Referrals Resulting In Detention		Referrals Not Resulting In Detention		Total Referrals	
Anglo	1,363	57.4%	11,158	68.9%	12,521	67.4%
Mexican-American	632	26.6%	2,943	18.2%	3,575	19.3%
Black	269	11.3%	1,631	10.1%	1,900	10.2%
Indian	107	4.5%	445	2.8%	552	3.0%
Other	2	0.1%	25	0.2%	27	0.2%
Total	2,373	100.0%	16,202	100.0%	18,575	100.0%

Adapted from Maricopa County Juvenile Court Center, Supplementary Report #2.*

*No pagination in original.

TABLE XXIII

1972 Female Detentions by Ethnicity

Maricopa County

	Referrals Resulting In Detention		Referrals Not Resulting In Detention		Total Referrals	
Anglo	849	70.1%	4,633	72.5%	5,482	72.1%
Mexican-American	238	19.7%	1,029	16.1%	1,267	16.7%
Black	55	4.5%	465	7.3%	520	6.8%
Indian	66	5.5%	247	3.9%	313	4.1%
Other	3	0.2%	15	0.2%	18	0.2%
Total	1,211	100.0%	6,389	100.0%	7,600	100.0%

Adapted from Maricopa County Juvenile Court Center, Supplementary Report #2.*

TABLE XXIV

1974 Male Referrals by Ethnicity
Maricopa County

Anglo	13,259	67.4%
Mexican-American	3,626	18.4%
Black	2,164	11.0%
Indian	385	2.0%
Other	233	1.2%
Total	19,667	100.0%

Adapted from Bureau of Preventive Services, personal correspondence.

TABLE XXV

1974 Female Referrals by Ethnicity
Maricopa County

Anglo	5,007	72.5%
Mexican-American	998	14.5%
Black	580	8.4%
Indian	197	2.9%
Other	122	1.8%
Total	6,904	100.0%

Adapted from Bureau of Preventive Services, personal correspondence.

A comparison of figures for total male and female referrals for 1972 and 1974 indicates an increase of 1,094 male referrals and a decrease of 696 female referrals. The male increase represents nearly a 6% change whereas the female decrease represents a 9% change. Without data from 1973 or 1975 it is difficult to judge whether these changes represent a pattern. However Table XXXI which projects referrals for 1976 and 1980 would seem to indicate a reduction is becoming a pattern. Table XXVI which reports referrals by age per 1,000 children for 1970, 1972 and 1974 indicates an overall reduction took place although not for every age group.

The reader can check the incidence of delinquency referrals for different age groups. The following table presents delinquency referrals as computed by age per thousand children. (Maricopa County Court Center, Supplementary Report #13, 1975, p. 3).

[INSERT TABLE XXVI HERE]

Between the ages of eight and eleven, children represent a 1% to 3% risk of referral. By age twelve a significant increase in delinquent referrals has occurred: up to 5%.

Referral rates consistently dropped from the years 1970 to 1974 for twelve to sixteen year old children. However, teenagers remain throughout these years the children at greatest risk, and sixteen year olds have a 16% to 20% chance to be referred for delinquent behavior.

TABLE XXVI

Delinquency Referrals per 1000 Children by Age Maricopa County

	YEAR		
Age	1970	1972	1974
8	9	10	9
9	14	16	13
10	20	22	21
11	30	33	28
12	52	49	44
13	85	75	69
14	127	110	101
15	162	143	130
16	195	163	158
17	86	79	79

Adapted from Maricopa County Juvenile Court Center, Supplementary Report #13, p. 3.

Data from the Bureau of Preventive Services enable Phoenix South Community Mental Health Center to compare overall delinquency referrals with number of referrals from the catchment area. These data can be broken down by sex, ethnicity, and census tract. Table XXVII represents ethnic data.[27] Table XXVIII represents all of the data as broken down by census tract. This second table provides in parentheses the total number of 1970 referrals from each census tract in the catchment area.[28] Plate II is a map of the catchment area and indicates delinquency referrals per census tract for 1974. The map provides in parentheses the total number of 1970 referrals per census tract.

[INSERT TABLES XXVII, XXVIII AND PLATE II HERE]

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[27] Male and female data were grouped by the Bureau of Preventive Services when compiling total figures. The data were separated by sex when reporting census tract information.

[28] Collated by Phoenix South Community Mental Health Center from data provided by the Department of Corrections.

TABLE XXVII[1]

1974 Referrals Phoenix South Community

Mental Health Center Catchment Area

Anglo	1,301	27.1%
Mexican-American	1,780	37.1%
Black	1,585	33.0%
Indian	113	2.4%
Other	22	0.5%
Total	4,801	100.0%

[1]Males, 3,673 (76.5) - females, 1,128 (23.5%)

Adapted from Bureau of Preventive Services, personal correspondence.

TABLE XXVIII

1974 Referrals - Phoenix South Community Mental Health Center Census Tracts

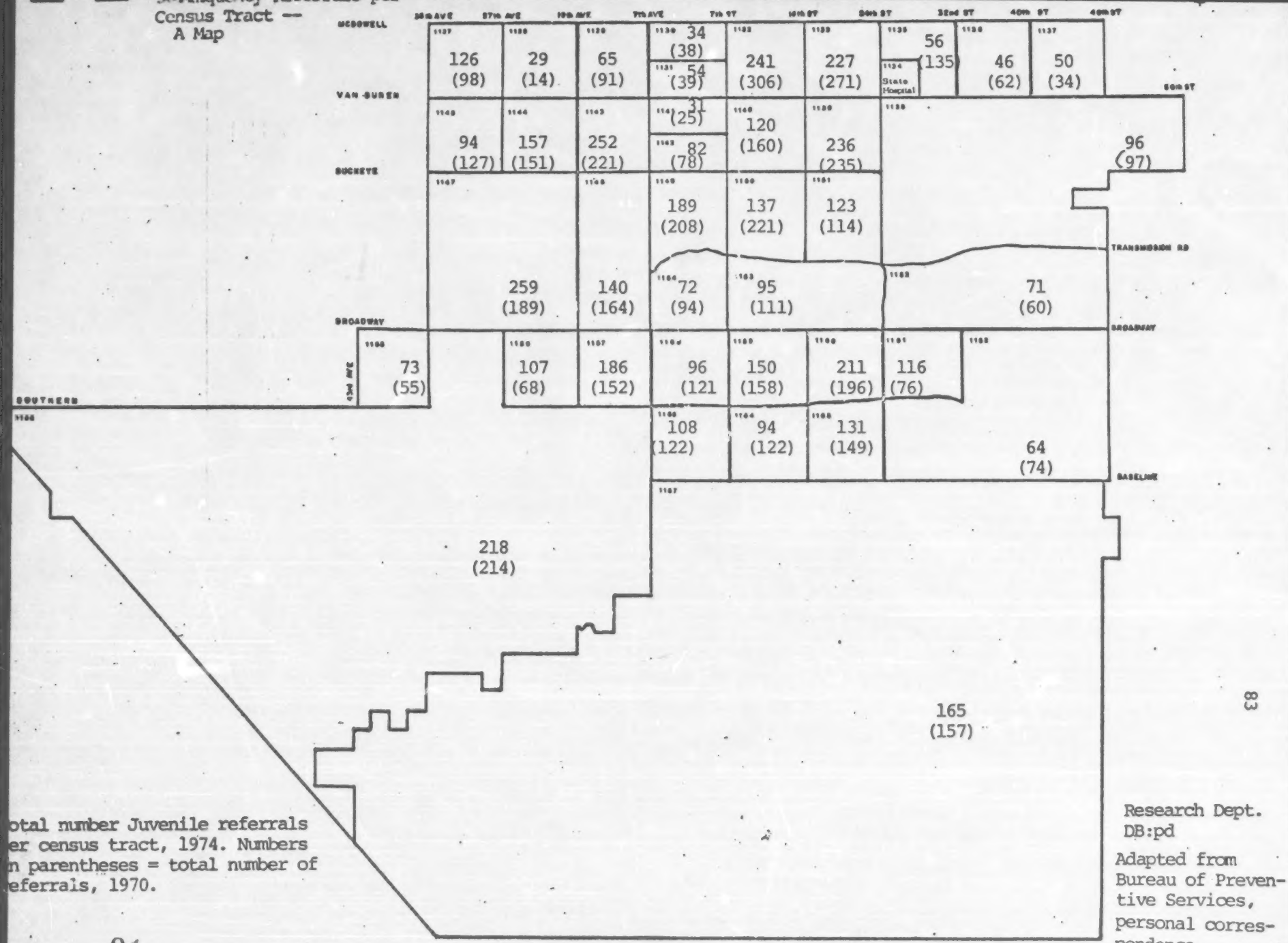
Phoenix South Community Mental Health Center Catchment Area

Census Tract	Male	Female	Anglo	Mex-Am.	Black	Ind.	Other	Total [1]
1127	82	44	81	37	7	1		126 (98)
1128	21	8	16	6		7		29 (14)
1129	47	18	36	17	1	11		65 (91)
1130	33	1	28	4		2		34 (38)
1131	36	18	32	6	13	3		54 (39)
1132	167	74	64	117	39	20	1	241 (306
1133	164	63	75	117	21	13	1	227 (271)
1135	49	7	33	14	8		1	56 (135)
1136	37	9	33	12	1			46 (62)
1137	40	10	47	1	2			50 (34)
1138	69	27	37	36	18	4	1	96 (97)
1139	182	54	28	90	114	3	1	236 (235)
1140	96	24	7	64	49			120 (160)
1141	16	15	13	8	5	4	1	31 (25)
1142	62	20	12	37	24	9		82 (78)
1143	167	85	37	66	146	2	1	252 (221)
1144	130	27	32	71	52	1	1	157 (151)
1145	67	27	47	34	12		1	94 (127)
1147	224	35	59	156	39	4	1	259 (189)
1148	109	31	13	38	88	1		140 (164)
1149	156	33	11	145	19	14		189 (208)
1150	109	28	18	105	13	1		137 (221)
1151	86	37	28	86	7	1	1	123 (114)
1152	54	17	3	2	64		2	71 (60)
1153	66	29	19	30	45	1		95 (111)
1154	52	20	29	41	1	1		72 (94)
1155	51	22	28	33	10	2		73 (55)
1156	92	15	3	3	100		1	107 (68)
1157	153	33	73	74	39			186 (152)
1158	77	19	42	45	8	1		96 (121)
1159	120	30	41	37	72			150 (158)
1160	172	39	8	23	179		1	211 (196)
1161	93	23	1	12	103			116 (76)
1162	47	17	41	5	16		2	64 (74)
1163	112	19	4	12	112	1	2	131 (149)
1164	73	21	37	14	43			94 (122)
1165	74	34	37	43	27	1		108 (122)
1166	171	47	88	84	41	3	2	218 (214)
1167	117	48	60	55	47	2	1	165 (157)
Totals	3,673	1,128	1,301	1,780	1,585	113	22	4,801 (5007)
	76.5%	23.5%	27.1%	37.1%	33.0%	2.4%	0.5%	100.0%

[1] Number in parentheses equal total referrals per census tract in 1970.

Adapted from Bureau of Preventive Services, personal correspondence.

Census Tract --
A Map



otal number Juvenile referrals
er census tract, 1974. Numbers
n parentheses = total number of
eferrals, 1970.

Research Dept.
DB:pd

Adapted from Bureau of Preventive Services, personal correspondence.

Table XXVIII can be used to determine the census tracts from which specific ethnic referrals were made with high frequency. For Mexican-American children these census tracts were 1132, 1133, 1147,1149, and 1150. For Black children these census tracts were 1139,1143, 1148, 1156, 1161, and 1163. For Anglo children these census tracts were 1127,1132, 1133, 1147, 1157, 1166, and 1167. For Indian children these census tracts were 1132,1133, and 1149.

A look at the census tracts numbers shows that two census tracts, 1132 and 1133, were the loci for high frequency of referrals of three different ethnic groups. Two census tracts,1147 and 1149, were the loci for high frequency referrals of two different ethnic groups.

Other information can be gained from Table XXVIII. A high incidence of referrals (at least 150) occurred in eleven census tracts. Nineteen census tracts showed an <u>increase</u> in referrals when their figures were compared with 1970 figures. Twenty census tracts showed a <u>decrease</u> in referrals. The increase/decrease figures may or may not be interpretable. Without 1974 population figures for the census tracts, interpretation of incidence of referrals cannot be validly made. In fact, what appears to be a small <u>decrease</u> could actually represent an <u>increase</u> of delinquency referrals per capita. This seeming paradox would be the case if a census tract has lost significant juvenile population since 1970, but maintained the same incidence of referrals.

It is possible to compare catchment area referrals with County referrals and thereby gain an idea of differences between the two. Tables XXIV and XXV indicate that in 1974 the overwhelming majority of children referred as delinquents in the County were Anglo (68.7%). Mexican-American children were a distant second (17.4%); Blacks were referred less (10.3%) than Mexican-American or Anglo children. Indian referrals were low (2.2%), as were other referrals (1.4%).

The catchment area figures tell a different story than reflected in the above figures when ethnic referrals from the County and catchment area are compared. Although many more referrals occurred outside the catchment area, the concentration of ethnic minority referrals occurred within the catchment area. Table XXIX presents data regarding this aspect of delinquency referrals.

[INSERT TABLE XXIX HERE]

As Table XXIX indicates, Anglo children comprised 27.1% of the referrals in the catchment area, but these same children included only 9% of all the 18,266 Anglo delinquency referrals in the County. Mexican-American children comprised 37.1% of the total referrals in the catchment area, and these same children included nearly the same percentage (38.5%) of all the 4,624 Mexican-American delinquency referrals in the County. Black children comprised 33% of the total referrals in the catchment area, but these same children included nearly 60% of all the 2,744 Black delinquency referrals in the County. Indian children, who comprised 2.4% of the total referrals in the catchment area, included nearly 20% of all the 582 Indian delinquency referrals in the County. Referrals of other ethnic juveniles comprised less than 1% of the total referrals in the catchment area, and these same children comprised over 6% of the 355 "other" referrals in the County.

The evidence is clear that many more referrals occurred outside the catchment area than within it; the catchment area referrals comprise less than 18% of the 26,571 delinquency referrals in the County. However, ethnic minority representation in delinquency referrals was disproportionate in the catchment area except among Mexican-Americans.

TABLE XXIX

Comparison of Total Referrals to Catchment Area Referrals in 1974

	Total		Catchment			Catchment's %
	N	%	N	%		of Total
Anglo	18,266	68.7	1,301	27.1	-	9.0
Mexican-Amer.	4,624	17.4	1,780	37.1	-	38.5
Black	2,744	10.3	1,585	33.0	-	57.8
Indian	582	2.2	113	2.4	-	19.4
Other	355	1.4	22	0.5	-	6.2
	26,571	100.0%	4,801	100.0%		

Adapted from Bureau of Preventive Services, personal correspondence.

Overall totals from 1970 and 1974 indicate a decline of 206 referrals, which is a 4.3% decrease in number of referrals from the catchment area. This rate of decrease is very similar to the rate (4.1%) projected by the Juvenile Court Center through 1980 for Maricopa County (MCJCC, Supplementary Report #13, 1975).

Projected referrals for Maricopa County for the year 1976 and 1980 were computed by using the average referral rates for 1970, 1972, and 1974. The following table, which forecasts a slight decrease (4%) in delinquency referrals by 1980, gives the predicted number of referrals by age (MCJCC, Supplementary Report #13, 1975, p.3).

[INSERT TABLE XXX ABOUT HERE]

TABLE XXX

Expected Delinquency Referrals by Age

Maricopa County

Age	1976	1980
8	171	195
9	271	315
10	420	437
11	660	614
12	1,124	994
13	1,889	1,637
14	2,910	2,563
15	3,821	3,567
16	4,635	4,498
17	4,690	4,954
Total	20,591	19,774

Adapted from Maricopa County Juvenile Court Center, Supplementary Report #13, p. 3.

Data concerning delinquency referrals in the County seem to indicate that delinquency referrals for all but ages nine, ten, and seventeen will decrease by 1980. No factors are readily apparent to account for an overall decrease in referrals. It would seem that the County Juvenile authorities expect such a decrease in incidence of referrals to occur without any influence from delinquency prevention programs. The County's report makes no reference to preventive intervention to account for projected decreases; the Juvenile Court Center report uses mean referral rates as a basis for 1976 and 1980 projections. The mean referral rates project a 4% decrease by 1980 (MCJCC, Supplementary Report #13. 1975).

The projected 4% decrease in juvenile delinquency referrals suggest certain questions regarding interpretation of the data. Does this 4% projected decrease provide a valid criterion against which to estimate effectiveness of preventive programs? For example, should referral rates in the County decrease more than 4%, would the County be correct to use such figures as indications of effective juvenile delinquency prevention? Or, should referral rates vary in either direction from the projected 4% decrease, would such a variation be a chance occurrence that could be measured? What variables are identified as influences that would decrease juvenile delinquency referral rates in the County?

One wonders whether the County's estimate of expected referrals, which has been computed solely from mean referral rates, in effect acknowledges the tenuous nature of efforts to prevent juvenile delinquency programs. That is, are delinquency referral rates projected to decrease even if preventive

efforts such as the Youth Services Bureau disappear? Evidence from federal programs organized in the 1960's to combat juvenile delinquency offer scant hope that preventive programs can be effective in reducing juvenile delinquency; these national efforts to prevent juvenile delinquency, colorfully reported by Moynihan (1969), appear to have had at best negligible effect.

Rather than end on a note of pessimism, this reviewer would prefer to offer a statement of optimism in the face of the high rates of juvenile delinquency in the catchment area and in the County. He fears, however, that available evidence cautions us to be guarded in our expectations of success when we tackle the problem of juvenile delinquency. At the same time, this reviewer believes the difficulties are not insurmountable. Even if guarded in our expectations, we can organize efforts to work effectively with children before they approach the high risk years for juvenile delinquency, viz, before they become teenagers.

The behavior therapists, whose programs are reported by Coleman (1972), offer evidence of effective intervention with juvenile offenders. These behavioral interventions occurred after-the-fact, it must be noted, not as efforts aimed at the level of primary prevention. Behavior therapists who work with institutionalized juvenile offenders have identified some key factors important in rehabilitation. Among these key factors are societal conditions such as markedly reducing "the caseload of the parole officers supervising the delinquent immediately placed on probation" (Coleman, 1972, p. 388), not mixing status offenders with criminal offenders, placing status offenders under skilled supervision rather than under lock-and-key, and opening channels of communication between juvenile gangs and "authority" figures such as police officers or social workers (Coleman, 1972).

The mental health center's concern for prevention of childhood emotional and behavioral disorders overlaps the correctional agencies' concern to reduce the incidence of juvenile delinquency. Reduction of behavioral and emotional disturbance appears to contribute to reduction of juvenile delinquency insofar as fewer symptoms in childhood are associated with less likelihood of teenage delinquency and schizophrenia.

MAJORITY CULTURE STUDIES

Abstract

This section reports research done predominently if not exclusively with children from the majority culture. A major longitudinal study and a study of child guidance patients comprise the material presented.

Two researchers (Kagan and Moss, 1962) completed a longitudinal study spanning twenty-five years. They present certain items as having major importance; the age period six to ten and the significance of sex role identification are two of these items.

One researcher (Shechtman, 1970) noted that symptoms for children at a child guidance clinic were age linked. She identifies certain symptoms which indicate pathology in five to eight year old children.

A major longitudinal study of psychological development is that of Kagan and Moss (1962). The researchers obtained data concerning eighty-nine White children from 1929 to 1954, and they used four age periods to group the data: 0-3, 3-6, 6-10, 10-14. Kagan and Moss intended to explore relations between childhood functioning and adult psychological status. Forty-five males and forty-four females comprised the eighty-nine children, who were subjects of the Fels Research Institute located in Yellow Springs, Ohio.

The fathers of these eighty-nine children were equally distributed among laborers, farmers, small businessmen, white-collar workers, and professionals. Religious backgrounds were primarily Protestant. Seventy-five per cent of the parents were high school graduates. Because the majority of the families would be appropriately termed middle socioeconomic level, there could be less than one-to-one correspondence to the target population of our urban poverty catchment area. However, certain findings of the Kagan and Moss study have been demonstrated in independent research of subjects from different socioeconomic level and racial background. A chief finding is the significance of the six to ten year old age period for psychological development. (See Robins, 1966; Glidewell, Mensh and Gildea, 1957; O'Neal and Robins, 1958; Shechtman, 1970; Conners, 1970; Kagan, 1966; Schiff and Kellam, 1967).

Kagan and Moss (1962) report many behaviors exhibited by a child during the six to ten age period forecast with moderate consistency certain related behaviors. The authors state that childhood passivity predicts withdrawal from stressful situations, behavior disorganization predicts ease-of anger arousal, and achievement predicts involvement in intellectual mastery (Kagan and Moss, 1962).

An important finding of the Kagan and Moss study is the significant influence of childhood sex-role identification upon adult functioning. Kagan and Moss discovered that "the individual's desire to mold his overt behavior in concordance with the culture's definition of sex-appropriate responses is a a major determinant to the patterns of continuity and discontinuity in his development" (Kagan and Moss, 1962, p. 269). The researchers also discovered that by their third year of age, children have begun to organize sex-role behavior.

The investigators noted that the degree to which a child maintains masculine or feminine sex-role interests remains stable from age three to fourteen.[29] They noted that when children age six to ten exhibited interest in opposite-sex behavior, their interests correlated significantly for similar adult behavior (males, $p < .001$ and female, $p \leq .01$). Thus, sex-role identification not only bears strong influence on later behavior but resists change according to Kagan and Moss (1962).

For the subjects of Kagan and Moss's study, the socioeconomic level of a child's family clearly related to his sex-typed interests as an adult. Kagan and Moss (1962) determined that lower middle socioeconomic level children were likely to adopt traditional sex-role responses whereas upper middle socioeconomic level children were likely to reject such responses; however, such patterns begin to crystallize no sooner than age ten. In this reviewer's opinion, the significance of all these findings regarding sex-roles

[29] Kagan and Moss identified interest in athletics, mechanical objects, and highly competitive activities as masculine; they viewed involvement in gardening, music, cooking, and noncompetitive activities as feminine. Such activities were not considered restricted to same-sex individuals but were seen as traditional sex roles for males and females in the Western culture.

is evident when one considers that the flexibility of one's behavior is significantly linked to the roles one perceives as permissible.[30]

Shechtman (1970) notes that symptoms are age-linked and that their persistence over time indicates possible pathology. In a study of 546 outpatients in a mental health clinic[31] she analyzed data in terms of severity and diffusion of psychopathological factors.[32] Her findings suggest that for five to eight year old males the persistence of the following symptoms indicates pathology: poor schoolwork, trouble concentrating, disobedience, fighting, phobias, nervousness, enuresis, negativism, and demanding attention. The symptoms differ only slightly for five to eight year old females: daydreaming, temper tantrums, poor schoolwork, trouble concentrating, disobedience, negativism, and demanding attention.

[30] The Woodlawn study of mental health and school children drew attention to the repeated finding that maladaptive behavior is more frequent among boys than girls. Sex role identity very probably would account for their disparity according to Kellam, Branch, Agrawal, and Ensminger (1975).

[31] 317 males and 229 females, ages 5 to 17, race and ethnicity not identified and presumed to be White.

[32] Derived from T. M. Achenbach. The classification of children's psychiatric symptoms: A factor-analytic study. Psychological monographs: General and applied, 1966, 80, p. 37.

GENERAL INTEREST STUDIES

Abstract

This section reports information of general interest in childhood behavior development. Specific variables such as culture, ethnicity, or socioeconomic level are not factors mentioned in any of the author's works reported here. The importance of stress is discussed first.

Two researchers (Senn and Solnit, 1968) identify certain developmental tasks and behavioral characteristics as functional for children and parents at specific ages of children. They also identify certain developmental tasks and behavioral characteristics as dysfunctional for children and parents at specific ages of children.

One researcher (Kagan, 1966) focuses attention on the age period of six to ten years. He considers certain responses critical for the development of the six to ten year old. By age ten Kagan believes that evidence demonstrates a child behaves in ways that will continue to differentiate her as an adult.

GENERAL INTEREST STUDIES

Longitudinal studies have demonstrated the existence of critical periods for development (Kagan and Moss, 1962; Robins, 1966; MacFarlane, 1954). These studies indicate that normal development for virtually all children includes stressful periods and crises which enable the children to learn to cope with difficulties. The notion of critical periods implies that certain tasks and problems may be identified with specific ages, and that the presence of certain behaviors beyond a certain age may appropriately be termed adaptive or masterful and other behaviors termed maladaptive or inept.

This reviewer recognizes that stress may and probably does vary from one culture to the next. Because cultures vary, decisions regarding proper development must recognize a tolerance to labels and acknowledge their relative worth.

Longitudinal studies strikingly suggest "that the early years of school attendance, ages six to ten, are the most common period of onset for all childhood behavior problems" (Robins, 1966 pp. 154-155). This finding is buttressed by research in the primary grades of different urban settings (Glidewell, Mensh, and Gildea, 1957; Schiff and Kellam, 1967; Kellam et al, 1975), by follow-up studies of child guidance clinic patients (O'Neal and Robins, 1958; Conners, 1970; Shechtman, 1970; Levy, 1969), and by follow-up studies of delinquents (Glueck and Glueck, 1959). Kagan reports that a child's early school years not only provide interested parties with a moderately reliable prognosis of his behavior for the next ten to fifteen years, but also a good period in which to intervene with those children who exhibit early signs of pathology (Kagan, 1966).

The data below present developmental tasks, acceptable behavioral characteristics, and minimal and extreme psychopathology for the critical period of five to twelve years old.[33] This developmental schema provides an initial focus for research efforts into needs assessment and planning of preventive mental health services for children. The information has been adapted from Senn and Solnit (1968), two pediatricians who are also child psychiatrists.

Senn and Solnit point out certain developmental tasks as well as acceptable behavioral characteristics for children and parents. A child's tasks are to master greater physical prowess, to further establish her self-identity and her sex role, to work toward greater independence from parents, to become aware of the world-at-large, to develop peer and other relationships, and to acquire learning, new skills, and a sense of industry; a parent's concomitant tasks are to aid the child's emancipation from parents, to reinforce self-identification and independence, to provide positive patterns of social and sex role behavior, to acclimatize the child to the world-at-large, to facilitate learning, reasoning, communication, and experience, and to promote wholesome moral and ethical values.

According to Senn and Solnit (1968) acceptable behavioral characteristics for children and parents are linked to the tasks in process for children ages five to twelve. For example, a child demonstrates better impulse control, accepts her own sex role and expresses that role in play and fantasy, develops pride, self-confidence, and less dependence on parents, begins to equate parents with peers and other adults, and exhibits

[33] In this reviewer's opinion the data are abstract goal statements and, in order to be used in a needs assessment, would require restatement in operational terms.

ambivalence concerning dependency, separation, and new experiences. A parent's acceptable behavioral characteristics during this period of his child's development include ambivalence towards separation, encouragement of independence, mixed feelings about parent surrogates, modeling of social and ethical behavior and standards, pleasure in a child's developing skills and abilities, satisfactions in life apart from his child, and support for the child as required.

Certain behavior disorders at this five to twelve year stage of life are considered by Senn and Solnit (1968) to be minimal for a child; others are considered minimal for parents. A child may become anxious and over-sensitive to school, relationships, or separation, may exhibit acting out behavior such as lying or temper outbursts, may regress, develop compulsive mannerisms, lack attentiveness, or develop somatic complaints. A parent may hasten separation prematurely or be disinclined to separate from the child, may become disinterested in the child, may foster fears, dependence, or apprehension, discipline inconsistently, restrictively, or moralistically, or undermine the child's confidence.

Senn and Solnit (1968) consider certain child or parental behaviors to be indicative of extreme psychopathology at this critical age. The criterion concerns the frequency, duration, and/or intensity of the behavior. For example, a child may completely fail to learn, become uncontrollably antisocial, develop severe obsessive-compulsive behaviors, become extremely withdrawn, apathetic, depressed, or self-destructive, assault others sexually, develop extreme somatic illness or speech difficulties, or establish absolutely no personal relationships. A parent may become extremely depressed and withdrawn, reject his child, be intensely aggressive and

hostile toward the child, develop uncontrollable fears, anxieties, or guilts, severely prohibit his child's independent strivings, or be completely incapable of family role functions.

Sobel (1975) identifies several features of early childhood which he terms significant for human development: learning sexual identification, acquiring a conscience, developing play skills, playing cooperatively, and fantasizing actively. He maintains that all children experience adjustment difficulties at this time, and that behavioral disturbances primarily stem from problems with sexual identification, peer competition, and proof of self-adequacy, self-worth, and autonomy. According to Sobel, adjustment reactions signal disturbance in a family system which includes a child who "has never developed adequate basic trust," a mother who "feels guilty and lacks self-esteem," and a father who "is nonsupportive in the marital relationship" (Sobel, 1975, p. 2089). Because such family disturbances hinder the child's abilities to cope with anxiety, Sobel says the child's behavior may exhibit not only symptoms of anxiety but somatic and physiological repercussions as well.

Kagan (1966) admits his presentation of factors important in the personality development of children is confined to children of the Western community. Because of Kagan's work with Central American as well as North American children, it seems unlikely to this reviewer that his findings apply only to White, middle-class children. According to Kagan, during the ages of six to ten a child is faced with developing the following critical responses:

1. To learn attitudes related to intellectual mastery.
2. To learn and practice an active social role with peers.
3. To practice behaviors and attitudes which define sex role standards and which crystallize a sex role identity.
4. To develop standards regarding rational thought, behavior independence, honesty, and responsibility.
5. To crystallize attitudes toward self primarily with one's peer group as a referrent.
6. To establish more firmly defense mechanisms to anxiety.

Kagan maintains that the major psychological dimensions responsible for individual differences among adults are observable by a person's tenth year of life. These dimensions include both responses indicative of healthy behavior and symptoms of maladaptive behavior. Thus, between the ages of six and ten a person has begun to organize several complicated responses, motives, and standards conducive to mental health. Among these responses, motives, and standards conducive to mental health Kagan lists the organization of defensive reactions to social rejection, conscious orientations to power and instrumental competence, and norms for sex role behaviors (Kagan, 1966).

In addition to organizing patterns of healthy behavior, the child has likely begun to develop some complex psychological symptoms which obtrude into his functioning; these symptoms could be harbingers of impending deviance. Kagan states one might notice in a child six to ten years old such representative symptoms as phobias, nightmares, asthma, ulcerative colitis, obsessional thoughts, compulsive actions, or motor tics (Kagan, 1966).

SUMMARY AND CONCLUSION STATEMENTS

The previous pages have been focused on variables with promise for assessing needs in the catchment area. Where do these considerations of some pertinent literature take us? From the literature we have identified variables which various researchers have demonstrated to be factors in healthy or deviant behavior development.

SUMMARY

Summary statements concerning the different sections of this review of literature can be written with a focus on implementing a needs assessment survey. The following paragraphs to this essay present such summary statements.

Glidewell's (1969) extensive report, for example, appears to confirm an earlier study (Glidewell, Mensh, and Gildea, 1957) which demonstrated the value of using a mother's ratings of behavior symptoms as a screening device for mental health practitioners. Conners (1970) used the same approach that Glidewell employed and reported findings of significance. Kellam, Schiff, and their colleagues in Woodlawn (Kellam and Schiff, 1967; Schiff and Kellam, 1967; Kellam et al, 1975) used teacher reports about childhood symptoms, whose value as prognostic devices they report favorably. Stoker and Meadow (1974) reviewed clinic reports in order to arrive at lists of childhood symptoms.

Many researchers report on the importance of the six to ten age period for the behavioral development of children regardless of racial, ethnic, and

socioeconomic backgrounds (Kagan, 1966; Kagan and Moss, 1962; Shechtman, 1970; Conners, 1970; Robins, 1966; Glidewell, 1969; Glidewell, Mensh and Gildea, 1957; Kellam et al, 1975; O'Neal and Robins, 1958). The years six to ten, a child's initial school years, have become the target of several research projects into behavior development.

Kagan and Moss (1962) state that behavioral continuity from childhood to adulthood links with sex-typed behavior standards more thanwith any other variable. One obvious factor to consider when measuring sex-roles is that cultures differ in the limits imposed on sex-typed behavior. Stoker and Meadow (1974) noticed these differences when they compared Mexican-American children and Anglo-American children.

Padilla and his colleagues (Padilla, Ruiz, and Alvarez, 1975) caution that identification of problems in the Spanish-speaking surnamed children may be contaminated by cultural differences between majority culture researchers and SSS persons. For example, these authors note that hearing voices is not considered a problem by the overwhelming majority of Mexican-American high school students. Padilla does not report whether Mexican-American adults associate hearing voices with "crazy" behavior, but the context of the article clearly implies that these adults would not label hearing voices as a behavior disorder. Padilla appears to be saying that other behaviors exist within the SSS culture which Anglos would likely consider pathological but which Mexican-Americans would identify differently. These behaviors are not specified by Padilla. A question remains for this reviewer whether there

are some conditions which lead SSS persons to label certain behaviors, for example, hearing voices, as deviant and pathological.[34]

The factors identified by O'Neal and Robins (1958; 1958a) as influential in the development of schizophrenia enables a profile to be drawn of pre-schizophrenic children. Such a profile would include multiple symptoms as well as symptoms of antisocial behavior according to O'Neal and Robins' data.

Robins (1966) listed thirteen symptoms which indicate pre-schizophrenic personality development. Robins noted that childhood theft is the behavior most predictive of sociopathic personality development. Juvenile Court Center data indicate that childhood theft is the major reason for delinquency referrals in Maricopa County.

The Juvenile Court Center predicts high rates of delinquency referrals for ages eight through eighteen in the years 1976 and 1980. Many of the behaviors for which teenagers are likely to be referred appear to have a history dating to the pre-teen years (five to twelve year old). For example, 1972, 1973, and 1974 data confirm that theft, burglarly, and other larceny are offenses of high incidence not only for teenagers but also for pre-teens. These three offenses in particular have been demonstrated to correlate significantly with the development of sociopathic personality (Robins, 1966).

The Juvenile Court Center data from 1972 to 1974 indicate that the following offenses are likely present in the catchment area with a high rate of incidence and prevalence for eight to twelve year olds; shoplifting, burglarly, vandalism

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34 Kiev, a community psychiatrist who made a study of Mexican-American folk psychiatry, has reported in a different study (Kiev, 1970) that a worldwide survey uncovered only four symptoms considered symptomatic of schizophrenia regardless of culture. One of these four symptoms is hearing voices.

or malicious mischief, runaway behavior, incorrigibility, and chronic truancy. Two of these offenses (burglary and runaway behavior) occur with high incidence in the catchment area for ten to nineteen year olds.

Efforts launched at the federal level to combat juvenile delinquency in large urban areas have proved less than promising. Moynihan (1969) reports on the efforts of a Presidential Commission, of the Office of Economic Opportunity, and of the Ford Foundation to use community organization tactics to prevent juvenile delinquency. These community organization efforts focused on education, job training, and job placement; it was thought these efforts would provide opportunities to persons whose poverty and frustrations led to juvenile delinquent behavior.

The efforts seem to have floundered, and very possibly they floundered because of the very premise on which they were organized, viz, opportunities will overcome juvenile delinquency. At the very time these federal programs were in their most promising days it is notable that Robins (1966, 198) cautioned that psychiatric data indicated no crucial connection between "the production of adult antisocial behavior," and "the frustrations consequent to low prestige and poverty in childhood."

Certain interventions seem to have some promise in reducing juvenile delinquency or, at least, modifying the behavior of juvenile delinquents. Coleman (1972) reports that behavior therapists have identified some key factors important in rehabilitation of institutionalized juvenile offenders. Many of these key factors are societal conditions such as reducing the caseload of persons who supervise juveniles placed on probation, segregating status offenders from criminal offenders, and opening channels of communications between juvenile gangs and the police as well as social workers.

CONCLUSIONS

Conclusions regarding the construction and implementation of a needs assessment survey can be drawn from the literature reviewed. Some conclusions regarding family therapy seem to follow logically should certain research data regarding the catchment area be demonstrated. The remaining paragraphs present conclusion statements regarding these matters of needs assessment and therapy.

The research projects reviewed by this author provide a basis for constructing a field survey instrument that would measure symptoms of five to twelve year old children in the South Phoenix catchment area. A list of symptoms could be garnered from the literature mentioned in the abstracts and in the summary statements. The literature would especially indicate strong support for a needs assessment of elementary school children, especially those children initially entering the school system.

Methodological approaches to assess elementary school age children have demonstrated favorable results in several independently conducted research projects. Specifically, the researchers report favorably not only the construction of behavioral checklists but the training of investigators to gather data by means of these lists. One aspect of the checklist construction is to probe for frequency, severity and duration of a reported symptom. With these methodological considerations in mind, it seems appropriate for this community mental health agency to devise an instrument, train investigators in its use, and interview parents and/or teachers about children placed in their charge.

Other aspects of needs assessment could use data from research which have focused on the development of schizophrenia. This research instructs us that

a profile of pre-schizophrenic children includes multiple symptoms as well as symptoms of antisocial behavior.

Sex-linked behavior has been demonstrated to be strongly correlated with behavioral continuity into adulthood. Because sex-linked behaviors are modeled for children primarily by adults significant to them, a field survey instrument could contain items to measure adults' perception of sex roles, for example, as regards competency, aggression, nurturance, passivity, and independence permitted males and females. Sensitivity to cultural differences would be called for any survey intended to measure sex-role identities.

Data regarding juvenile delinquency argue a strong case for preventive efforts to be directed in the pre-teen years at such behaviors as shoplifting, burglarly, vandalism, runaway behavior, chronic truancy, and incorrigibility. Preventive efforts could be aimed at eight to twelve year old children in the catchment area. Such efforts would find these children by 1980 to be in their teens, the years when juveniles are at greatest risk of delinquency referral.

A number of juvenile offenses clearly relate to family system problems, for example, running away from home and declaring a child to be incorrigible. The presence of antisocial models in the family has been demonstrated by Robins (1966) to be a major factor in the production of behavior which comes to the attention of juvenile authorities. With these family factors which are influential in producing juvenile delinquency in mind, it seems appropriate to present the family system as an important target in efforts to prevent juvenile delinquency.

To focus on the family in juvenile delinquency prevention efforts implies family services be provided to residents of the catchment area. Minuchin's (1967) profiles of urban slum families offer a model to consider in researching

catchment area families and delivering family services. It would be informative to devise means to research whether or not family systems in the catchment area correspond to the family profiles delineated by Minuchin. If a correspondence can be demonstrated, Minuchin's ideas regarding how to work therapeutically with these families would then bear scrutiny. His therapeutic ideas are presented at length in Families of the Slums. If his ideas prove viable, they bear directly on program planning efforts.

Because Families of the Slums is written about family therapy, the book's messages about large-scale intervention programs seem to focus on individuals or individual families rather than upon social groups or social forces. In a number of contexts in which the authors mention community programs, this reviewer expected statements with community organization focus to appear, but the book retained its focus on the family. One message appeared clear, however. Attempts to intervene with persons with these poverty family profiles or with communities in which these families exist run head-on against a long history of behavior which is extremely resistant to extinction and which governs interaction with external sources.

It certainly seems unreasonable to laud community organization as a means to combat juvenile delinquency when data from Robins (1966) and the history of federal efforts (Moynihan, 1969) are known. However, some intervention efforts have proven helpful. For example, there appears to be some hope to counter juvenile delinquency from certain behavioral interventions (Coleman, 1972). And certainly checklists which would assess children's needs could note the presence of symptoms which are highly predictive of sociopathic personality development. A target could be made of areas in which families report a high

incidence and prevalence of these antisocial symptoms in pre-teen children. These notions bring us back to earlier conclusion statements made about designing preventive efforts for children who will be at highest risk of delinquency referral by 1980.

One immediate focus for these preventive efforts would be designing a study to compare the pre-teen age behavior of teenage delinquents with the current behavior of children 8 to 12. Variables predictive of delinquency could possibly be identified, and eight to twelve year olds at risk (that is, who exhibit behavior predictive of teenage delinquency) could become subjects for intervention. Control subjects would be needed to insure that the pre-teenage behavior of teenage delinquents significantly differed from the pre-teenage behavior of teenagers who are not delinquents.

This survey has reviewed numerous research studies. These studies have identified variables predictive of a range of behavioral problems to which children and adolescents fall prey. These problems range from school maladjustment through social deviancy to schizophrenia.

List of symptoms:		Source
trouble eating, sleeping, with other children, digesting food, with grownups, unusual fears, nervousness, thumbsucking, overactivity, sex, daydreaming, temper tantrums, crying, lying, stealing, destructiveness, rejection of school, wetting, speaking.	7 or more reported symptoms associated with disturbance in 86% of children	Glidewell, Mensh & Gildea (1957)
	3 or less reported symptoms associated with adjustment in 78% of the children.	
	1 or less reported symptom associated with adjustment in 91% of the children	

	Identifies	Source
1. trouble eating	children likely to develop schizophrenia.	O'Neal & Robins (1958)
2. trouble sleeping	a) maladjusted from adjusted children ($p < .02$)	Glidewell (1969)
	b) child clinic patients from children not in clinic	Conners (1970)
2a) restless sleep or awakens at night	White children in clinics and not in clinics.	Conners (1970)
2b) nightmares	a) White middle socioeconomic level children in clinics.	Conners (1970)
	b) White lower not in clinics.	Conners (1970)
	c) Anglo girls in clinics.	Stoker & Meadow (1974)
3. trouble getting along with other children	a) maladjusted from adjusted children ($p < .02$)	Glidewell (1969)
	b) middle class from lower class children ($p < .05$)	Glidewell (1969)
	c) girls from boys ($p < .02$)	Glidewell (1969)
3a) fighting	a) 5-8 year old males diagnosed psychopath	Shechtman (1970)
	b) Mex-Am. male children in clinics	Stoker & Meadow (1974)
	c) symptom highly associated with development of sociopathic personality	Robins (1966)

3b) problems making friends	child clinic patients regardless of ethnicity or socioeconomic level	Conners (1970)
3c) problems keeping friends	child clinic patients regardless of ethnicity or socioeconomic level	Conners (1970)
3d) problems with siblings	child clinic patients regardless of ethnicity or socioeconomic level	Conners (1970)
3e) few if any friends	a) Anglo boys and girls in clinics	Stoker & Meadow (1974)
3f) no personal relationships	extreme psychopathology in a 5-12 year old child	Senn & Solnit (1968)
3g) poor social relationships	Anglo boys and girls in clinics	Stoker & Meadow (1974)
4. Digestion problems	no research appears to have correlated findings	
5. Trouble with grown-ups		
5a) fear of people	White lower socioeconomic and White middle socio-economic. Black children in Woodlawn from children in Conners' study	Kellam, et al., (1975)
5b) troubles with authority	first grade lower socio-economic Black males	Kellam, et al., (1975)
5c) negativism	a) Mex-Am. male children in clinics	Stoker & Meadow (1974)
	b) 5-8 yr old males and females diagnosed psychopath	Shechtman (1970)
5d) obstinancy	Mex-Am male children in clinics	Stoker & Meadow (1974)
5e) running away from home	a) Mex-Am female children in clinics	Stoker & Meadow (1974)
	b) associated with development of sociopathic personality	Stoker & Meadow (1974)
5f) disobedience	a) children likely to develop schizophrenia	O'Neal & Robins (1958)
	b) 5-8 yr old males and females diagnosed psychopath	Shechtman (1970)

	5g) overdependency on mother	children likely to develop schizophrenia	O'Neal & Robins (1958)
	5h) incorrigibility	a) children likely to develop schizophrenia	O'Neal & Robins (1958)
		b) associated with development of sociopathic personality	Robins (1966)
		c) indicates presence of sociopathology	Robins (1966)
	5i) staying out at night beyond hour permitted	a) associated with development of sociopathology	Robins (1966)
		b) indicates presence of sociopathology	Robins (1966)
	5j) sleeping outside the home without permission	associated with development of sociopathic personality	Robins (1966)
	5k) parents feel able to influence children's behavior	correlates with children's level of adjustment	Glidewell (1969)
6.	Unusual fears	girls from boys ($p < .02$)	Glidewell (1969)
	6a) fear of new situation	White lower & middle socioeconomic children in clinics	Kellam et al (1975)
	6b) fear of being alone	White lower & middle socioeconomic children in clinics	Kellam et al (1975)
	6c) fear of going to school	White lower and middle socio-economic children in clinics	Kellam et al (1975)
	6d) phobias	a) 5-8 yr old males diagnosed psychopathic	Shechtman (1970)
		b) children likely to develop schizophrenia	O'Neal & Robins (1958)
7.	Nervousness	a) 5-8 yr old males diagnosed psychopath	Shechtman (1970)
		b) maladjusted from adjusted	Glidewell (1969)
		c) Anglo boys and girls in clinics	Stoker & Meadow (1974)
8.	Thumbsucking		
	8a) immaturity	Mex-Am female children in clinics	Stoker & Meadow (1974)
9.	Overactivity	a) maladjusted from adjusted ($p < .02$)	Glidewell (1969)

	b) Mex-Am male children in clinics	Stoker & Meadow (1974)
	c) Mex-Am female children in clinics	Stoker & Meadow (1974)
9a) problems concentrating	a) first grade lower socio-economic Black males	Kellam, et al. (1975)
	b) 5-8 yr old males & females diagnosed psychopath	Shechtman (1970)
9b) impulsivity	Mex-Am male children in clinics	Stoker & Meadow (1974)
9c) impulsive to reckless behavior	children who develop socio-pathic personality	Robins (1966)
9d) acting out behavior	maladjusted from adjusted children ($p < .02$)	Glidewell (1969)
10. Sexual activity		
10a) sexual assault on other children	a) symptom associated with sociopathological personality	Robins (1966)
	b) extreme psychopathology of children five to twelve	Senn & Solnit (1968
11. Daydreaming	a) maladjusted from adjusted	Glidewell (1969)
	b) 5-8 yr old females diagnosed psychopathological	Shechtman (1970)
12. Temper tantrums	a) 5-8 yr old females diagnosed psychopath	Shechtman (1970)
	b) Mex-Am male children in clinics	Stoker & Meadow (1974)
	c) Anglo girls in clinics	Sotker & Meadow (1974)
13. Crying		
13a) trouble with feelings	Black lower socioeconomic level children	Kellam et al., (197
13b) crying spells	Mex-Am male children in clinics	Stoker & Meadow (1974)
13c) depression	a) Mex-Am females children in clinics, especially among 6-8 yr olds	Stoker & Meadow (1974)
	b) children likely to develop schizophrenia	O'Neal & Robins (1958)

14. Lying	child clinic patients, White & Black lower & middle socio-economic	Conners (1970)
14a) lying without apparent motive	a) children likely to develop schizophrenia	O'Neal & Robins (1958)
	b) associated with development of sociopathology	Robins (1966)
15. Stealing	a) the major predictor of sociopathological personality development regardless of sex or socioeconomic level	Robins (1966)
	b) White & Black, lower & middle socioeconomic children in clinics	Conners (1970)
	c) Mex-Am male children in clinics	Stoker & Meadow (1974)
16. Property Destruction	maladjusted from adjusted children ($p < .02$)	Glidewell (1969)
16a) fire setting	child clinic patients - White or Black, lower or middle socioeconomic	Conners (1970)
17. Rejection of school or school problems	child clinic patients - Black or White, middle or lower socioeconomic	Conners (1970)
17a) academic problems	a) Mex-Am male children in clinics	Stoker & Meadow (1974)
	b) Anglo boys and girls in clinics	Stoker & Meadow (1974)
	c) 5-8 yr old males and females diagnosed psychopathological	Shechtman (1970)
17b) truancy	associated with the development of sociopathological personality	Robins (1966)
17c) dropping out of school	Mex-Am male children in clinics	Stoker and Meadow (1974)
17d) anxious or over-sensitive to school	minimal psychopath for 5-12 yr old	Senn & Solnit (1968)
17e) fear of going to school	White lower & middle socio-economic level children in clinics	Kellam et al., (1975)

18. Enuresis	a) 5-8 yr old children diagnosed psychopath	Shechtman (1970)
	b) Black lower socioeconomic level children	Conners (1970)
	c) Anglo boys and girls in clinics	Stoker & Meadow (1974)
19. Speech or hearing problems		
19a) stuttering	Black lower socioeconomic children not in clinics	Kellam et al., (1975)
19b) speech problems	Black lower socioeconomic level children	Conners (1970)
19c) speech problems other than stuttering	White lower socioeconomic children in or not in clinics	Kellam et al., (1975)
19d) hearing problems	children likely to develop schizophrenia	O'Neal & Robins (1958)
19e) auditory hallucinations	common symptom of schizophrenia regardless of culture	Kiev (1970)

BIBLIOGRAPHY

BOOKS

Blackham, G. and Silberman, C. Modification of child and adolescent behavior. Belmont, California: Wadsworth, 1975.

Coleman, J. Abnormal psychology and modern life. (4th Ed.) Glenview, Ill.: Scott, Foresman, 1972.

Frank, Lawrence K. The cultural patterning of child development. In Frank Falkner (Ed.) Human Development, Phila: W. B. Saunders & Co., 1966, 408-32.

Glasser, W. Schools without failure. NY: Harper and Row, 1969.

Glidewell, J. Studies of mothers' reports of behavior symptoms in their children. In Saul Sells (Ed.) The definition and measurement of mental health. Washington, D. C.: National Center for Health Statistics, 1969, 181-217.

Glueck, S. and Glueck, E. T. Predicting delinquency and crime. Cambridge: Harvard Univ. Press, 1959.

Herzog, E. and Sudia, C. E. Children in fatherless homes. In B. M. Caldwell and H. N. Riccuiti (Eds.) Review of child development research. Vol. 3. Chicago: University of Chicago Press, 1973, 141-232.

Kagan, J. and Moss, H. Birth to maturity: A study in psychological development. NY: John Wiley and Sons, 1962.

Kellam, S. and Schiff, S. Adaptation and mental illness in the first-grade classrooms of an urban community. In M. Greenblatt, P. Emery, and B. Glueck (Eds.) Poverty and mental health. Washington, D.C.: American Psychiatric Association, 1967, 79-91.

Kellam, S., Branch, J., Agrawal, K., Ensminger, M. Mental health and going to school. Chicago: University of Chicago Press, 1975.

Kiev, Ari. Normal and abnormal behavior. Commentary. In Otto von Mering and Leonard Kardan (Eds.) Anthropology and the behavioral and health sciences. Pitts: Univ. of Pittsburgh Press,1970, 143-46.

Macfarlane, J. Developmental study of the behavior problems of normal children between 21 months and 14 years. Berkeley: University of California Press, 1954.

BIBLIOGRAPHY

BOOKS

Meeks, John A. Behavior disorders of childhood and adolescence. In A. Freedman, H. Kaplan, and B. Sadock (Eds.) Comprehensive Textbook of Psychiatry, Second Edition. Williams and Wilkins Co., Baltimore; 1975, 2127-35.

Minuchin, S. Discussion of Dr. Leo Srole's paper. In M. Greenblatt, P. Emery, and B. Glueck (Eds.) Poverty and mental health. Washington, D.C.: The American Psychiatric Association, 1967, 147-50.

Minuchin, S., Montalvo, B., Guerney, B., Rosman, B., Schumer, F. Families of the Slums. NY: Basic Books, 1967.

Moynihan, D. P. Maximum feasible misunderstanding: Community action in the war on poverty. New York: Free Press, 1969.

Richmond, Julius B. and Lipton, Earle, L. Studies on mental health of children with specific implication for pediatricians. In G. Caplan (Ed.) Prevention of mental disorders in children. NY: Basic Books, 1961, 95-121.

Robins, Lee N. Deviant children grown up. Baltimore: The Williams and Wilkins Co., 1966.

Schiff, S. and Kellam, S. A community-wide mental health program of prevention and early treatment in first grade. In M. Greenblatt, P. Emery, and B. Glueck (Eds.) Poverty and mental health. Washington, D.C.: American Psychiatric Association, 1967, 92-102.

Senn, Milton and Solnit, Albert J. Problems in child behavior and development. Philadelphia: Lea and Febriger, 1968.

Sobel, Raymond. Adjustment reaction of infancy and childhood. In A. Freedman, H. Kaplan, and B. Sadock (Eds.) Comprehensive Textbook of Psychiatry, Second Edition. Williams and Wilkins Co., Baltimore: 1975, 2088-93.

Stoker, D. and Meadow, A. Cultural differences in child guidance clinic patients. International Journal of Social Psychiatry, 1974, 20, 196-202.

U. S. Dept. of Commerce, 1970 census of population and housing. Washington, D.C.: U.S. Government Printing Office, 1972.

BIBLIOGRAPHY

PERIODICALS

Bowlby, J. et al. The effects of mother-child separation: A follow-up study. British J. Medical Psychology, 1956, 29, 211.

Bowlby, J. A note on mother-child separation as a mental health hazard. British J. Medical Psychology, 1958, 31, 247.

Caplan, M. G., and Douglas, V. I. Incidence of parental loss in children with depressed mood. J. Child Psychol. & Psychiat. and Allied Disciplines, 1969, 10, 225-32.

Conners, C. Keith. Symptom patterns in hyperkinetic, neurotic, and normal children. Child Development, 1970, 41, 667-82.

Glidewell, J., Mensh, I., and Gildea, M. Behavior symptoms in children and degree of sickness. Am. J. Psychiat., 1957, 114, 47-53.

Hosford, R. and Bowles, S. Determining cuturally appropriate reinforcers for Anglo and Chicano students. Elementary School Guidance Counseling, 1974, 8, 290-300.

O'Neal, P., and Robins, L. Childhood patterns predictive of adult schizophrenia: A 30-year follow-up study. Am. J. Psychiat., 1958, 115, 385-91.

_____. The relation of childhood behavior problems to adult psychiatric status. Am. J. Psychiat., 1958[a], 114, 961-69.

Padilla, A., Ruiz, R., and Alvarez, R. Community mental health services for the Spanish-speaking/surnamed population. American Psychologist, 1975, 30, 892-904.

Pollitt, E., Eichler, A., and Chan, C. Psychosocial development and behavior of mothers of failure-to-thrive children. American Journal of Orthopsychiatry, 1975, 45, 525-37.

Shechtman, Audrey. Age patterns in children's psychiatric symptoms. Child Development, 1970, 41, 683-93.

UNPUBLISHED MANUSCRIPTS

Maricopa County Juvenile Court Center. Supplementary Report #1, 1973.

_____. Supplementary Report #2, 1973.

_____. Supplementary Report #8, 1974.

BIBLIOGRAPHY

UNPUBLISHED MANUSCRIPTS

Maricopa County Juvenile Court Center. Supplementary Report #12, 1975.

_____. Supplementary Report #13, 1975.

_____. Overview, age, and offense, 1974.

Wignall, C. Where the Phoenix South children and youth with emotional and behavioral problems live. A social area analysis. Phoenix South Community Mental Health Center, 1975.